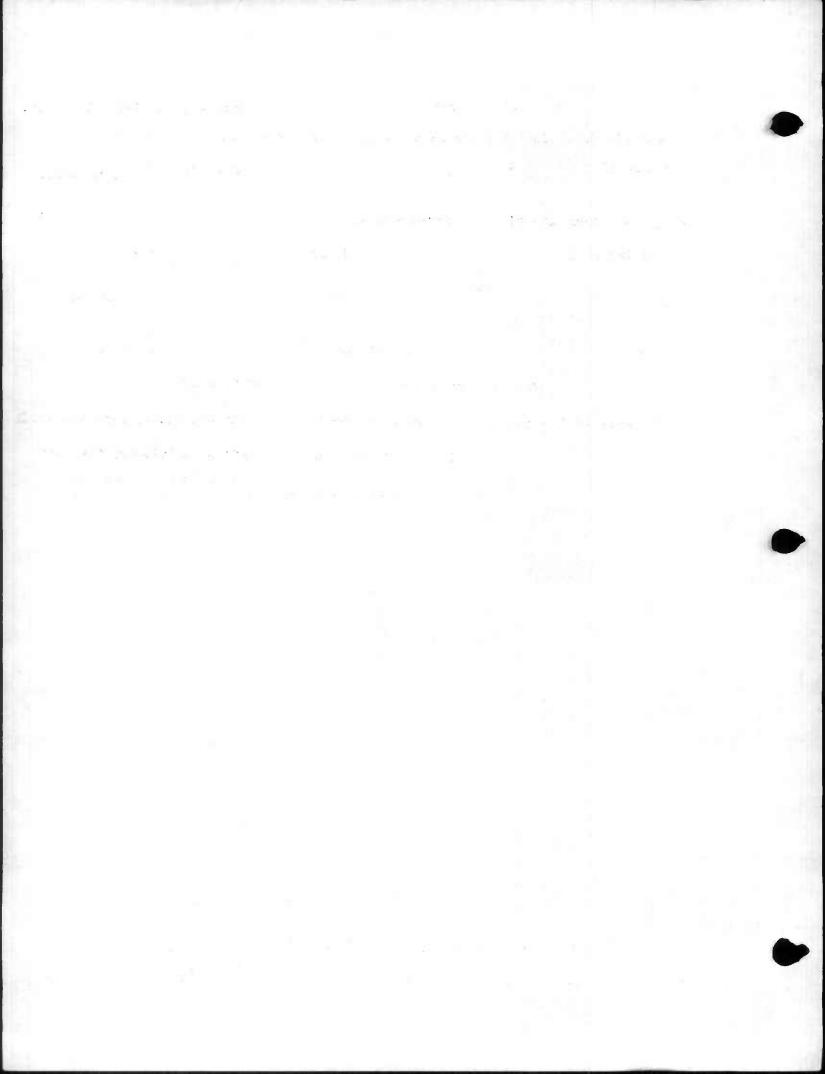
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Chloe Lee February 28 1998 3:00 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Genesis Elder Care Severna Park Center Severna Park Hours Min. S. Data of Birth (Month, Day, Year) OCt • 12, 1910 5. Social Security Number 7. Aga (In yrs. last birthday) if Under 1 Yaar Birthplaca (Stata or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days 214 66 3381 87 Director Connecticut Usual Residence of Decedent the Merylend 10a. Stata 10b County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Riviera Beach 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8601 Bay Road 21122 U.S. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

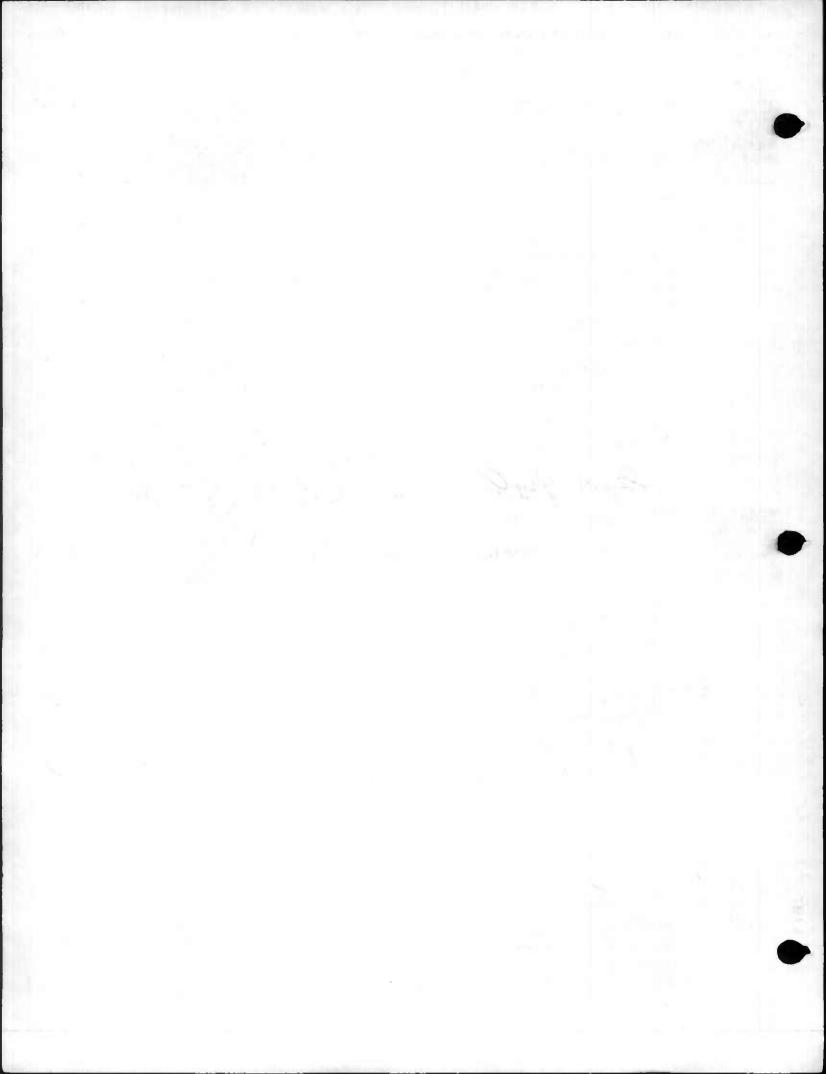
1 Yas 2 No
If Yes, Give
Yaar or Datas: Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ØNo Specify: Specify: þ White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry illed within 7 Hygiene. other than "n Eiementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Heelth and Mentel Hygient important: if tenn 27 is marked other that sny injury or other traumetic access. Homemaker Own Home 12th 17. Father's Name (First, Middle | Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Rhoda Dolph Frederick VanOstrand 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Riviera Beach, Maryland 21122 Joan Lipford / daughter 8601 Bay Road 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/4/98 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donetiony 5 ☐ Other (Special) 21. Signature of Funeral Service Licens 22. Nama and Addrass of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease, or cr. vications that ceused tha death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List of my one ceuse on each line. Approximata Interval Barri Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel 2 Weer ARTERIOSCIENTE CARDIOVACULAR disease or condition resulting In death) Examiner DISGASA Examiner physician end s the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of): use as the Part II. Other eignificant conditions contributing to death but not rasulting in the underlying causa givan in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Vee 2 No 3 Probably 4 Unknown DEMENTIA ģ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 100 certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was cese referred to medical 28. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA al or Attending Physics after death.

In Director: After this ed in by the funeral d this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edicai 29a. Certifier (Check only one) within 2 29b. Signature and tille of cartifier 29c. License number 29d. Data signed (Month, Day, Year) D 21776 Mh ed 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) My 203 & PATARSED AVE SARIMORE 2/22/ MUNURA 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Tulia Da doon-Randall 0 3 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

					Certific	cate of	Death		Reg. No.) (0002
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Physic /Medi		Herbert	_orenz					FEB	25	1998	1455
Exami		4e. Fecility Name (If not institution, give	street end number)				4b. City, Town, or	Location of Deet	h 4c. County	of Deeth	
	_,	St. Agnes Hosp	ital				Balti	more	N/A		
Funeral		Social Security Number 6. Security Number		n yrs. lest bi	Mor	Inder 1 Year	If Under 24 Hrs		th ev. Year)	9. Birthp	lace (State or Foreign
Director		212-36-9242	XM 2□ F 5	8	Yrs.		100.0	APR 6,			yland
pui *		Usuel Residence of Decedent 10e. State 10b. County	1/	o City Tou	n or Location						
aryla sho	5	MD N/A			altimo					110	Od. Inside City Limits
Ne N	ecto			ъ.							1 Yes 2 □ No
E 0 4	2	10e. Street end Number			101	f. Zip Code			10g. Citizen of	Whet Coun	try?
eth v	Funeral Director	1321 Church St					226		USA		
er de	une	11. Maritel Status	12. Was Decedent Eve Armed Forces?	r In U,S.	13. Wes D	ecadent of specify Cub	Hispanic Origin? (S ben, Mexican, Puerl	pecify Yes or No o Ricen, etc.)	14. Red Ble	e - America ck, White, e	
Maryland 21215-0020 d 2 should be filed within 72 hours effer deeth with the Maryland th end Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinet must be notified at	by	1 ☐ Nevar Married 2 ☒ Marrled 3 ☐ Widowed 4 ☐ Divorcad	1 ☐ Yes 2V No If Yes, Give Year or Dates:			as 🎾 No			Specif		hite
15-002	Be Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16e	Decedant's	Usuel Occu	petion during most of wor	rkina	16b. Kind of B	usiness/Ind	Justry
2121 d within giene. r than	mpi	Elemantary/Secondary (0-12)	College (1-4or 5+)				during most of word)				
d 212 filed with Hygiene. other than	ပိ	4			labore	er					rovement
be filed that it has it	Be	17. Fether's Nema (First, Middle, Lest) UNK. Lore	~~				18. Mother's Nar			ne)	
aryla should and Men	2						Eliza	beth U	NK.		
Maryland 2 d 2 should be filed v th end Mental Hygie 7 is marked other t traumatic event, ID		19e. Informent's Name/Reletionship (7	ype, Print)	19t	o. Mailing Add	drass (Straa	t and Number or Ru	ural Route Numb	er, City or Town,	Stete, Zip	Code)
		Joan C. Lorenz/wi		1	321 Ch	urch	St. Balt	imore,	MD 21226	5	
Ore,		20e. Method of Disposition 1 □ Burlal 2 ☒ Cremetion 3 □	Removel from Stete	cameta	of Disposition ry, cremetory	or other ple	oce)	Dete	20c. Location -	City or To	wn, State
Limen men men men men men men men men men		4 ☐ Donation 5 ☐ Other (Specify)	Metro	Crema	tory,	Inc. 02/	27/98	Baltin	ore,	MD
Baltimore, pemit. Peges 1 er Department of Hee Important: If Item 2 any Injury or other once.		21. Signeture of Fonaral Service Lican-	9)		Crema	e and Addra	Society	of Maryl	and In	C	
		Edward A. Gra	gorchik		299 1	Freder	ick Rd.	Baltimor	re. MD 2	1228	
		23a. Pert1. Enter the diseese, or comp shock, or heart feilure. List only of		death. Do							Approximete Interval Between
Physician											Onset end Deeth
/Medical		Immedieta Causa (Final disease or condition	anoxic.	ence	nhale	natt	ry				2 days
Examiner		resulting in deeth)	e anoxic .	to (or es a	consequence	a of):	1				
P #	inei	_									
cords, P.O. Box 68760, requires that the death certificate be executed een signed by the ettending physician end hould be deteched for use as the buriel-trensit	Examiner	Sequentially list conditions,	Due	to (or es e	consequence	of):					
SO, se ex		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury								1	
68760, ifficete be exe g physician est the buriel.	Medicai	that initiated events resulting in deeth) Lest	Due	to (or es e	consequence	of):					
A Ging p	Me										
BO)			0.								
o der	Physician	Part II. Other eignificant conditions co	ntributing to death but no	ot resulting i	n tha undarlyi	ing cause gi	ven in Pert I.	23b. Did	tobacco uee co	ntribute to	the cause of death?
that the de deteched i	Ph	hypertension						10	Yes 2 No	3 Prob	ably 4 Unknow
es their	þ	77 .									
cord v require been si	ted	cerebrovascu	lar acci	dent	•			24e. Wes	en eutopsy ormed?	eve	ere eutopsy findings eileble prior to
Rec e lew r	Completed		1		4 1 1					of o	npletion of cause deeth?
The I	50	rossible history	of myor	ardio	1 info	arcti	on	1 🗆	Yes 2 No	1 🗆	Yes 22 No
Vital Records, sicien: The lew requires the certificate hes been signe rector, page 2 should be considered.	Be (25. Wes case referred to medical / exeminer?			/		26. Piece of Dec	eth (Check only	one)		
dis X	To	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/O	utpetient 3	DOA Ot	her: 4 Nursing H	lome 5 Resi	dence 8 □Oth	er (Specify	′)
OTO OTIO		27. Manner of Deeth 1 ☑ Natural 5 ☐ Panding	28e. Dete of Injury (Month, Dey Ye	28b.	Time of Injury	28c. Inju Wo	ry et	28d. Describe	how Injury occur	red	
Vision Attending r death. ector: After by the fune	atic	2 ☐ Accident Investigation			M		Yes 2□No				
DIVISION The Attending Fatter death. I Director: After dein by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicida determined	28e. Plece of Injury building, atc. (S	At home, fe	erm, street, fa	ctory, offica		28f. Location (City or To	Street end Numb	er or Rure	Route Number,
D FEED TO	Ce			,,,							
To the Hoppith or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai	Check only 2 Medical Exam	eician: To the best of m	y knowledge	a, deeth occur	rred at tha ti	me, date and place	, and dua to tha	causa(s) and ma	annar as sta	ated.
Within 24 To the Fu	Med	310)	end menner stated.								
To To	~	29b. Signetura end title of cartifier		Α. Δ		29c. Lican		_	29d. Dete signe		Dey, Year)
		Mongrah Unowlo	msaeny,	M.V.		1	0-9145	>	FEB 2	6,10	198
H		30. Name end eddrass of person who c	ompleted causa of daeth	(Itam 23e)	(Type, Print)						
		KONGSAK CHANTOR	NSAENG, M.D.	ST. A	GNES H	USPITA	11900 CA	TON AVE	. BALTIM	ORE .	MD21229
Sta	te	31. Date filed (Month Day Year)	Juna Rayas	Signeture	***					1	
Registr	ar	MENT U D 1338	Juna Mayasa	-Handle	100						



State of Maryland / Department of Health and Mental Hygiene

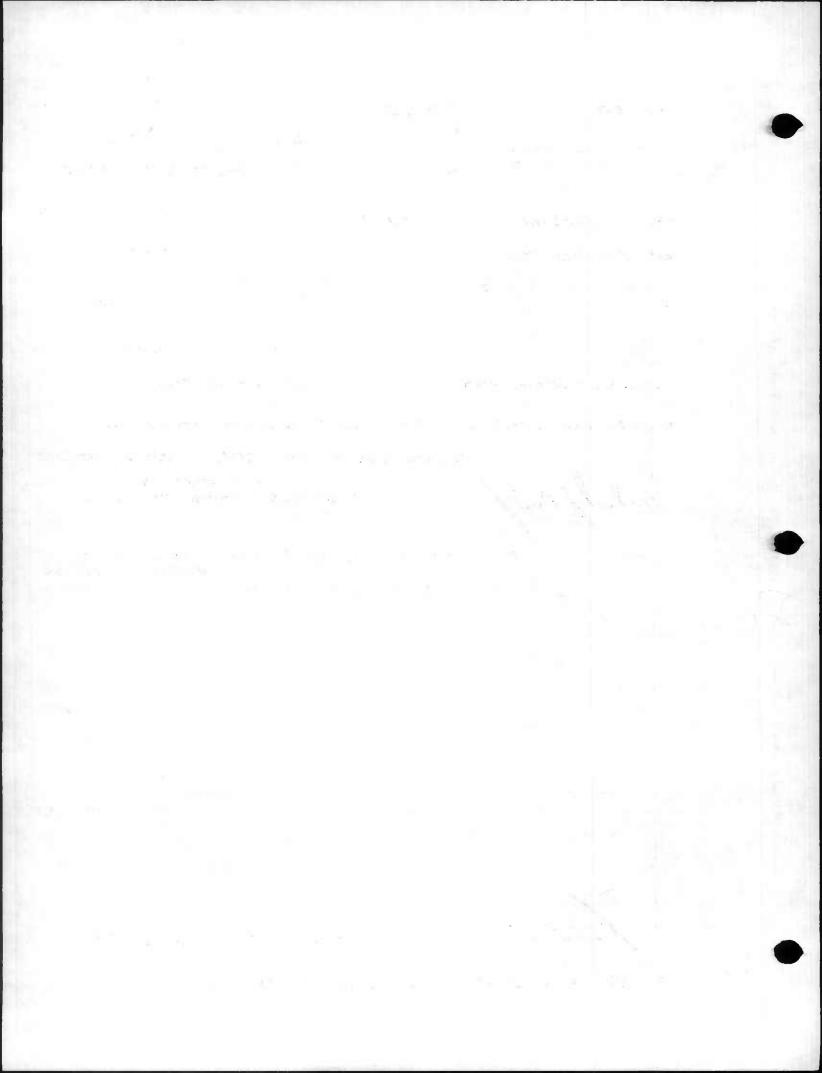
06503 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3 Time of Deeth Month **Physician** 11:30 p.m. February DOROTHY LEONARD /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Timonium Baltimore Stella Maris Hospice
5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Aug. 21, 1911 7. Age (In yrs. lest birthday) If Under 1 Year 9. Birthplece (State or Foreign **Funeral** Deys 1□M 2ÅF Months Hours 214-44-5621 86 Yrs. Maryland Director Usual Residence of Decedent Marylend 10a Stete 10b. County show 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 28a-1 . bM Baltimore Timonium the 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 6 U.S.A. 21093 238 213 Eastsprings Road Funeral or Items 12. Was Decadent Ever in U.S. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Maritel Status Black, White, etc. filed within 72 hours efter Yes 2X No 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify Specify: White by 3√ Widowed 4 Divorcad Year or Dates: natural Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry of hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Medical Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mentel Christian Ferdinand Meeks Mary Elizabeth Wagner 2 traumetic end l 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Hem 27 I 4 Discovery Ct. Baltimore, Maryland 21234 Baltimore, other Harry J. Leonard, Jr./Son 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Depertment of Important: If any Injury or once. 3/3/98 Baltimore, Maryland New Cathedral Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility Ruck Towson Funeral Home, Inc. 21204 1050 York Road Towson, Maryland 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical RESPIRATORY FAILURE WITH ENDSTRUCTURE CHRONIC OBSTRUCTURE Examiner Due to (or es e consequenca of): PULMONARY! Examiner ACUTE MYOCARDIAL INFARCTION Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events Due to (or es e consequenca of): Box 6876 Physician/Medical Due to (or es e consequence of) resulting in deeth) Lest attending 997 Attanding Physician: The law requires that the dauth þ P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Onknown Division of Vital Records, þ Completed 24b. Were autopsy findings eveileble prior to 24e. Wes an autopsy performed? peed completion of cause of death? has certificate 2 3490 1 Yes 1 ☐ Yes 2 ☐ No director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 1 ☐ Yes 25000 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 5 Pending investigetion 1 Neturel 2 Accident death. 1 ☐ Yes 2 ☐ No or Attend efter death Director: the 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e Certifying Phyelcien: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check onh one) To the I within 2 the contribution of six 5 29b. Signeture and 1 29c. License number 29d. Date signed (Month, Dey, Yeer) 96 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registraris Signatura de 10 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

MAR 0 3 1998



State of Maryland / Department of Health and Mental Hygiene

hysician	_	Decedent's Name (First, Middle Marion		hwing		Leon	nhard	2. Date of Dee Month March		¥98	3. Time of Death 1:30AM		
Medical xaminer	40	Facility Name (If not institution				деог	4b. City, Town, or l		4c. County	of Death	1.50/11		
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eral ector	1	Social Security Number 216-44-9827	6. Sex 1 ☐ M 2 ☐ F		91 Yrs.	Months Days		8. Date of Birth (Month, Day NOV • 2	9 1906	Wisco	ge (Stata or Foreig Snsin		
rector	10	sual Residence of Decedent Da. State 10b. County MD. Balti	more	10c. C	ity, Town or Lo Towson	ocation				100	I. inside City Limits		
Funeral Director	10	Ne. Street and Number 800 Southerl	y Rd.			10f. Zip Code 212	86		log. Citizen of W	/hat Country USA	/?		
by		. Marital Status 1 □ Nevar Marriad 2⊠ Marri 3 □ Widowad 4 □ Divorced		acedant Ever in I Forces? s 20 No Give Dates:		Was Decedent of If Yas, specify Cul 1 ☐ Yes 2 ☑ No	Hispanic Orlgin? (Span, Mexican, Puart	pacify Yes or No- pacify Yes or No- pacify Yes or No-	14. Race Black Specify:	- Americer k, White, et	c.		
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Be	1 1	'. Father's Name <i>(First, Middl</i> e, <i>l</i> Julian	.ast)		Thw	ing	18. Mother's Nan	ne (First, Middle,	Maiden Sumem		hores		
2	-	e. Informant's Name/Relationsh	ip (Type, Print)				1	rai Route Numbe	Shores Route Number, City or Town, State, Zip Code)				
		s. Joan Emrich					St. Livon	ia, Mich	igan 4	8150			
Department of Health Important: If Item 27 I any Injury or other tra	20	e. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		- 01-1-	cemetery, cres eadowri	osition (Name of metory or other pl dge Ceme	tery 3	Date -3-98	20c. Location - Elkridg	e, MD			
DUCe.	2	Signature of Funeral Servica I	icansae		22	2. Name and Add Ruc 105	ress of Facility { Towson York Rd	Funeral Towson	Home: I	1204			
ler lexaminer	d re	nmediate Cause (Final sease or condition soulting in death) equentially list conditions, any, leading to immediate	a		(or as a consector as a consector)	tal s	Loker	med i'v	~		1d 2400		
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Physician/M	Pi	sutting in death) Last				quence of):	iven in Part I.	23b. Did t	~1		the cause of death		
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State of Maryland / Depar

tment of Health and Mental	Hygiene	Q	0	C	5	n	1
ificate of Death	Reg. No.	U	U	O	J	U	0

Physician	
/Medical	
Examiner	

ARNOLD F. LONEY, 3. Time of Death 10:54 AM

1 Yes 2 No

Funeral Director

the Maryland death

Directo

Funeral

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Completed

Be

To

Examiner

Physician/Medical

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Completed

Be

10

Certification:

Medical

ir than "natural", or items 23a or 28s-f show the Medical Examiner must be notified at

permit. Pagas 1 and 2 should be filled within 72 hours after c Department of Health and Mantai Hygiene.
Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Mantain and Pagas. Maryland 21215-0020

> **Physician** /Medical Examiner

certificate be axecuted

Box 68760

Division of Vital Records, P.O.

Attending

attanding physician and for usa as the bunal-tran signed by the a has page 2 certificata this funaral or Attending after death. à 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day JR. 28, 1998 FEB. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth BALTIMORE N/A JOHNS HOPKINS HOSPITAL S.I.C.U If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth August, Dex Year) 1973 MARYLAND 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6 Sex 9. Birthplace (Stete or Foreign Months Days Hours Min. M 2□ F 218-86-9157 24 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits MARYLAND N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zlp Code 1647 RALWORTH ROAD 21218 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Yes 2 No Specify: NEGRO Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) UNEMPLOYED N/A 10TH N/A 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) ARNOLD F. LONEY, SR. DENISE HARRISON 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BEAVETTE LONEY / wife 1647 RALWORTH ROAD BALTO, MD. 21218 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State BALTIMORE CEMETERY MARCH 6,1998 Balto, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME tomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or comshock, or heert feilure. List only 21213 Approximate Interval Between Onset and Death inshot Wound-Immediate Cause (Final disease or condition resulting in death) Due to (o as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of) Due to (or as e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Onknown

24a. Was an autopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of deeth?

2 No

26. Place of Death (Check only one)

16 es 2□ No

muliple

25. Was case referred to medical examiner? 1XXYes 2□ No

27. Manner of Death

1 Neturel

2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined 28a. Dete of Injury (Month, Day Year)

Hospital: XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28c. Injury at Work?

111 Penn Street, Baltimore, Maryland 21201

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office on sheet 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1300 BK. Patterson Auk Avenue 1300 BK. Patterson Paul In.

1300 BK. Patterson Paul Avenue 1300 BK. Patterson Paul In.

1000 BK. Patterson Paul III.

1000 BK. Patterson Pau shot times

1300 Blk. Patterson Parle Avenue

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end manner as steted.

XX Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifie

29c. License number O.C.M.E

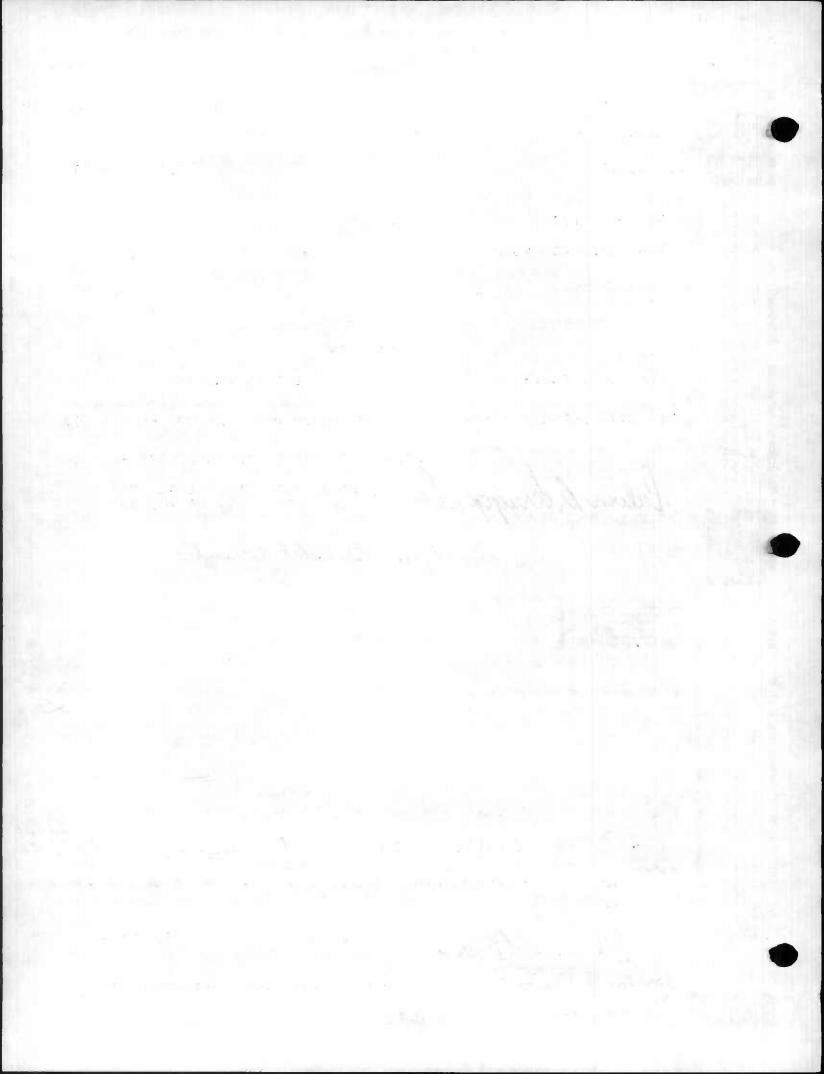
29d Date signed (Month, Dey, Year) MARCH 1, 1998

lute is 30. Name and address of person who op eted cause of death (Item 23a) (Type, Print)

Dennis J 31. Date filed (Month, Day, Year)

MAR 0 3 1998





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth JOSEPH LORIS FEBRUARY 28 1998 1105 AM 4e. Facility Nama (If not institution, giva street and numbar) 4b. City. Town, or Location of Deeth 4c. County of Deeth GLEN BURNIE Anne ARUNDEL ARUNDEL HOSPITAL NURTH | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Months Deys Hours Min. | 1 - 21 - 1902 6. Sex. 1 → M 2 □ F 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign HUNGRY Yrs 213-10-8183 Usual Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 PNo MARYLAND ANNE ARUNDEL GLEN BURNIE 10f. Zip Code 10g. Citizen of What Country? 7964 PIPERS PATH 21061 U.S.A. 12. Wes Decadant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Year or Dates: Was Decedent of Hispenic Origin? (Specify Yas or Not Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritel Stetus 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry Elementery/Secondary (0-12) College (1-4or 5+) YEARS REPAIRMAN SHIPYARD 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Surname) PHILIP LORIS ELIZABETH SPEK 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21108 19a. tnforment's Name/Relationship (Type, Print) ALBERT J. LORIS (SON) 8213 BERNARD DRIVE N. MILLERSVILLE, MARYLAND 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 03-04 1 X Burlal 2 ☐ Cremation 3 ☐ Removat from State 1998 HOLY CROSS CEMETERY 4 □ Donetion 5 □ Other (Specify) BROOKLYN PARK, MD 21. Signeture of Funeral Service 22. Name end Address of Facility THE SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MARYLAND 21061 in plications that caused the death. Do not anter the mode of dying, such as cerdiac or respiretory errest, to one cause on each line. 23a. Pert1. Enter the No. Approximete tntervel Between Onset end Deeth tmmediete Ceuse (Final disease or condition resulting in death) Due to (or es e consequence of) Sequantially tist conditions, if eny, teading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Lest Due to (or es e consequence of): Due to (or as a consequence of): Part tl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy 1 ☐ Yes 2 No 25. Wes cese referred to medicet axeminer? 26. Plece of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Rasidence 6 ☐ Other (Specify) 1 Yes 25 No 1 Npatient 2 □ ER/Outpetient 3 □ DOA 27. Manner of Deeth 28a. Dete of tnjury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation Naturel

Physician /Medical Examiner

Examiner

Physician/Medicai

by

Completed

2 Accident

4 Homicide

31. Dete filed (Month, Day, Year)

MAR 03

3 Suicide

29a. Certifier (Check only one)

Physician

/Medical

Examiner

Director

þ

Completed

Funeral

Director

ortant: If Item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the West cal Examiner must be notified at

2 should be filed within 72 hours efter nend Mental Hygiene.

permit. Pages 1 and 2 sl Department of Health en Important: If Item 27 Is n any Injury or other traur

the Marylend

burial-transit pue physician s the burial

Box 68760.

Division of Vital Records, P.O.

this After or Attending effer death. Director: Aft

Registrar

29b. Signeture end title of cryptier

6 Could not be determined

28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and mannar steted.

1 ☐ Yes 2 ☐ No

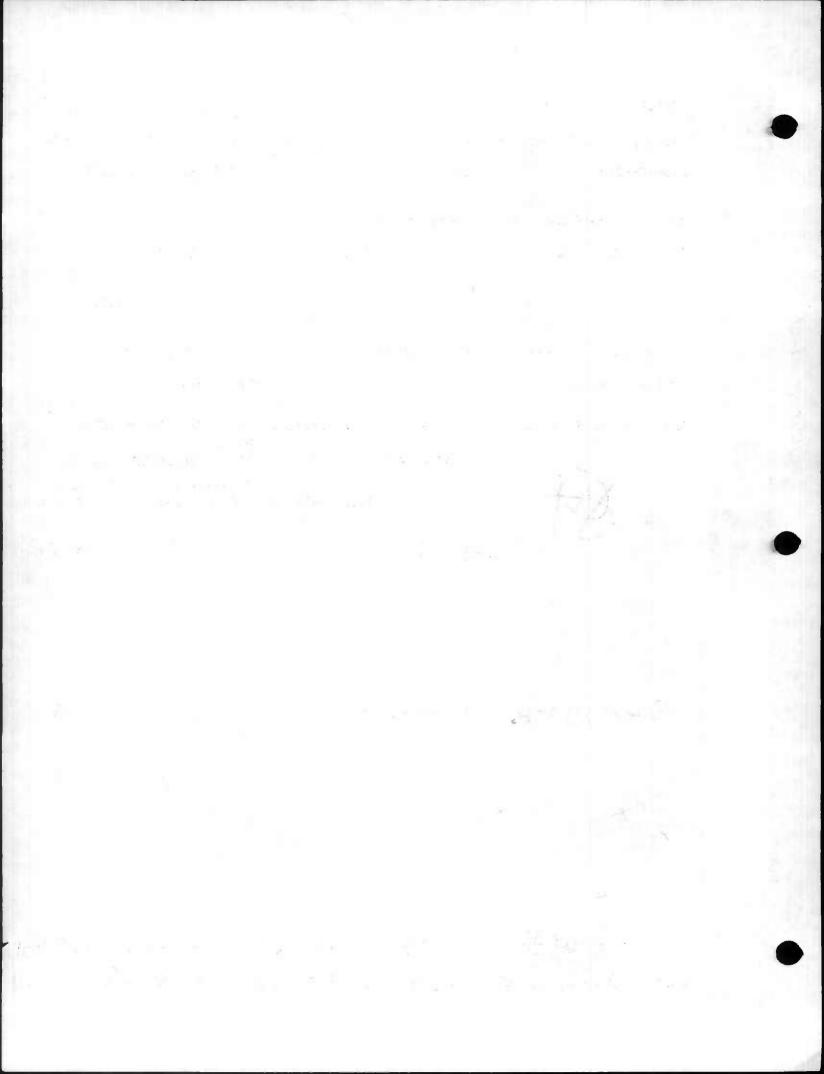
28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

HUSP. DR. GLEN BURNIE, MD 21011

30. Name end eddress of person who completed ceuse of deeth (ttem 23e) (Type, Print)

KORT KOFI

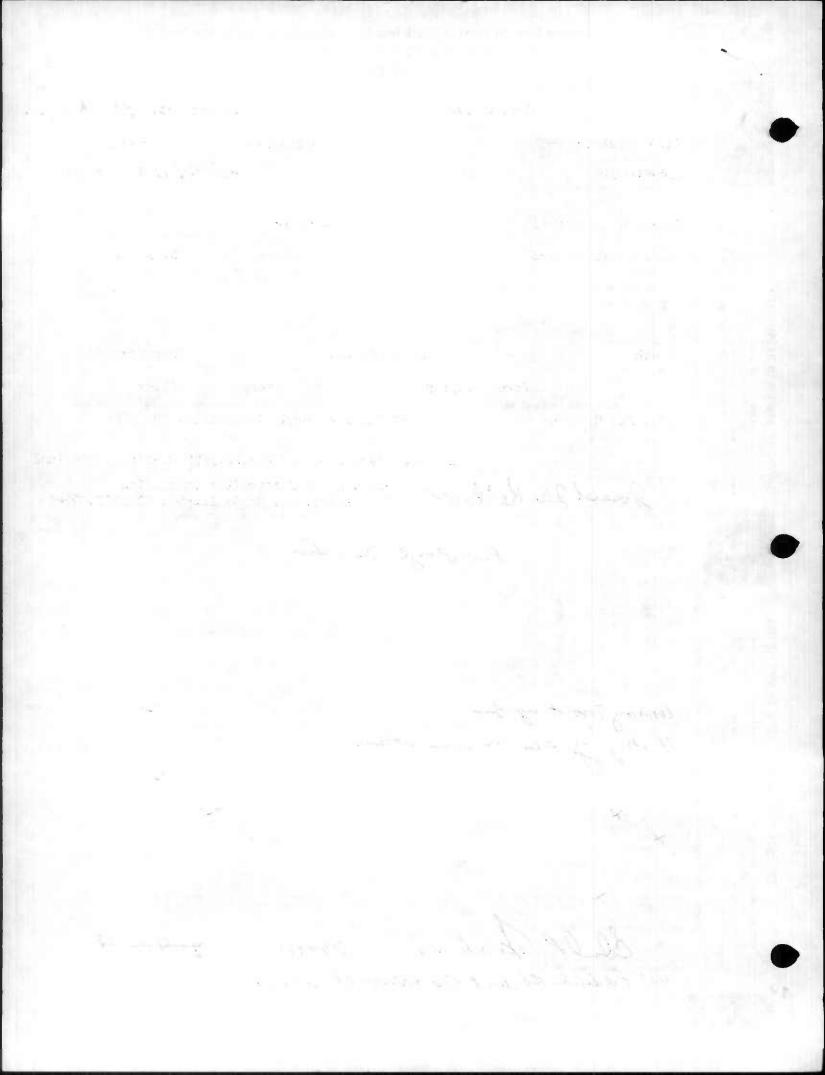
301 32. Registrer's Specific



State of Maryland / Department of Health and Mental Hygiene

Item: 29d per M.D G-757 3/3/98 reb Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daeth 3. Time of Death Day **Physician** February 23, 1998 Cornie Lee 4:35p.m. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Nema (If not institution, giva street and number) Examiner Sykesville If Undar 24 Hrs. 8 6153 Oklahoma Road Carroll 5. Social Security Number If Undar 1 Year 8. Data of Birth (Month, Day, Yaar) 9. Birthplaca (Stata or Foraign 7. Aga (In yrs. lest birthday) **Funeral** Days Months Hours 1 □ M 2 🖾 F Yrs. July 28, 1918 Virginia 79 214-64-0056 Director Usual Rasidence of Decadent with the Merylend 10d Insida City Limits 10a Stata 10b. County 10c. City. Town or Location in than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Directo Sykesville Carroll Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21784 6153 Oklahoma Road U. S. A. permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mentel Hygiene. Important: if firen 27 la marked other than "natural", or items 23 any Injury or other traumatic event, as Medical Estating man. Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 220 No If Yas, Giva Year or Detas: Wes Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarlcan Indien, Black, Whita, atc. 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2€ No Specify: Specify: White by 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) 16a, Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) Collega (1-4or 5+) Elamantary/Secondary (0-12) Business Woman Entrepreneur 4th 18. Mothar's Nama (First, Middle, Maidan Sumema) 17. Fathar's Nama (First, Middle, Last) Jeffrey Taylor Mary Wilder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19e. Informant's Name/Ralationship (Type, Print) Sykesville, MD 21784 6153 Oklahoma Road Mrs. Kay C. 20a. Method of Disposition 20b. Placa of Disposition (Nama of camatary, crematory or other placa) Data 20c. Location - City or Town, Steta 1 Burial 2 □ Cramation 3 □ Ramovel from Stata 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery Feb. 28, 1998 Woodlawn, Maryland 22. Nama end Address of Facility
Loring Byers Funeral Directors, Inc 21. Signatura of Funaral Sarvice Licensee any Ir 2w. 8728 Liberty Rd. Randallstown, MD 21133-4784 23a. Part1. Enter the disaese, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only one cause on each line. Approximete Interval Between Onsal end Death **Physician** /Medical Immediate Ceuse (Finel disaasa or condition rasulting in daath) END Hoyl Denner
Due to (or es e consequence of): Examiner Examiner physician end the buriel-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that Initiated avants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or es a consequance of): 98 ettending nse use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part ii. 23b. Did tobacco use contribute to the cause of death? ed by the detached signed by t 1 Yes 2 No 3 Probably 4 Unknown Completed by Admocorum when 24b. Ware autopsy findings evailable prior to 24a. Was an autopsy should been s completion of causa of deeth? certificete hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No Physician: 25. Was case referred to medical axeminar? Be 26. Piece of Daath (Chack only one) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Masidanca 6 ☐ Othar (Specify) 10 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Dey Year) 28d. Dascribe how Injury occurred 27. Mennar of Death 28b. Time of 28c. Injury at Work? Certification: After Attending 1 Neturel 2 ☐ Accident 5 Pending 1 Yas 2 No deeth. investigation within 24 hours efter deett To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicida 28a. Placa of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) in by 4 Homicide ò 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the ceusa(s) and mannar stated. edical 29a. Cartifiar (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura end/jitla of certifie 29c. Licanse number 30. Neme and edd person who completed cause of deeth (Item 23e) (Type, Print) m & 100 Goronle 10 7:228 405 Frederick Rd 32. Ragistrato Signature Aundalia State MAR 0 3 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Day Ralph 30 vellen Marc on 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Moures Caunty Hospital Columbia MD. Howard 7. Age (In yrs. last birthday) If Undar 1 Yaar | If Under 24 Hrs. 8. Dete of Birth (Months Deys Hours Min. (Month, Dey, Year) 5. Social Security Number Birthpiece (State or Foreign Country) Months Deys Hours 11℃ M 2□ F 270-38-1218 55 May 15, 1942 Indiana Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 21 No Maryland | Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3355 Marston Rd. 21157 USA 12. Was Decedant Evar in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Bleck, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ No 1961— If Yes, Give 1 Nevar Married 2 Married 1□ Yes 2□ No f Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE. 1981 15. Decedent's Education (Spacify only highest greda completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retirad) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 years 4 vears Engineer Communications 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Raymond H. Luellen Fannie Hipkins 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Frances D. Luellen (Wife) 3355 Marston Rd. Westminster, MD 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Locetion - City or Town, State Dete 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Baltimore Washington Crem 3-2-98 | Laurel, Maryland 21. Signeture of Funerei Service Licensee 22. Name end Addrass of Facility Loring Byers Funeral Directors, Inc. 23a. Part. Entar the disease, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or raspiretory arrast, shock, or heart failure. List only one ceuse on eech line. 8728 Liberty Rd. Randallstown, MD 21133 Approximate Interval Betw Onsal and Death Immediate Ceuse (Finel disease or condition resulting in daath) Ke nal METASTATIC Candio Sequentially list conditions, if eny, leeding to Immediate causa. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Mellips. 24e. Wes an autopsy performed? 24b. Were eutopsy findings eveilebla prior to completion of cause of deeth? 2 X No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminar? 26. Plece of Deeth (Check only one) Hospital: 1 Inpalient

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

2

Completed

2

10a. State

Funeral

Director

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter a Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations.

altimore, Maryland 21215-0020

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death

Examiner Physician/Medical ρ Completed Be 2

Certification:

Medicai

ettending physician end for use as the buriel-transit hes this certificate director, funeral After 1 the ctor: à

certificete be executed Box 68760. Records, P.O. Division of Vital I Attending death.

To the Horpital or At within 24 hours after of To the Eureshi Direct

State Registrar

William SAMMY MD.

any my

5 Pending Investigation

6 Could not be

1 Yes 2 No

27. Menner of Deeth

Neturel 2 Accidant

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture end the of certific

Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpetient 3 DOA

Sertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Madical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. 29d. Dete signed (Month, Dey, Year)

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

28d. Describe how injury occurred

28c. Injury at Work?

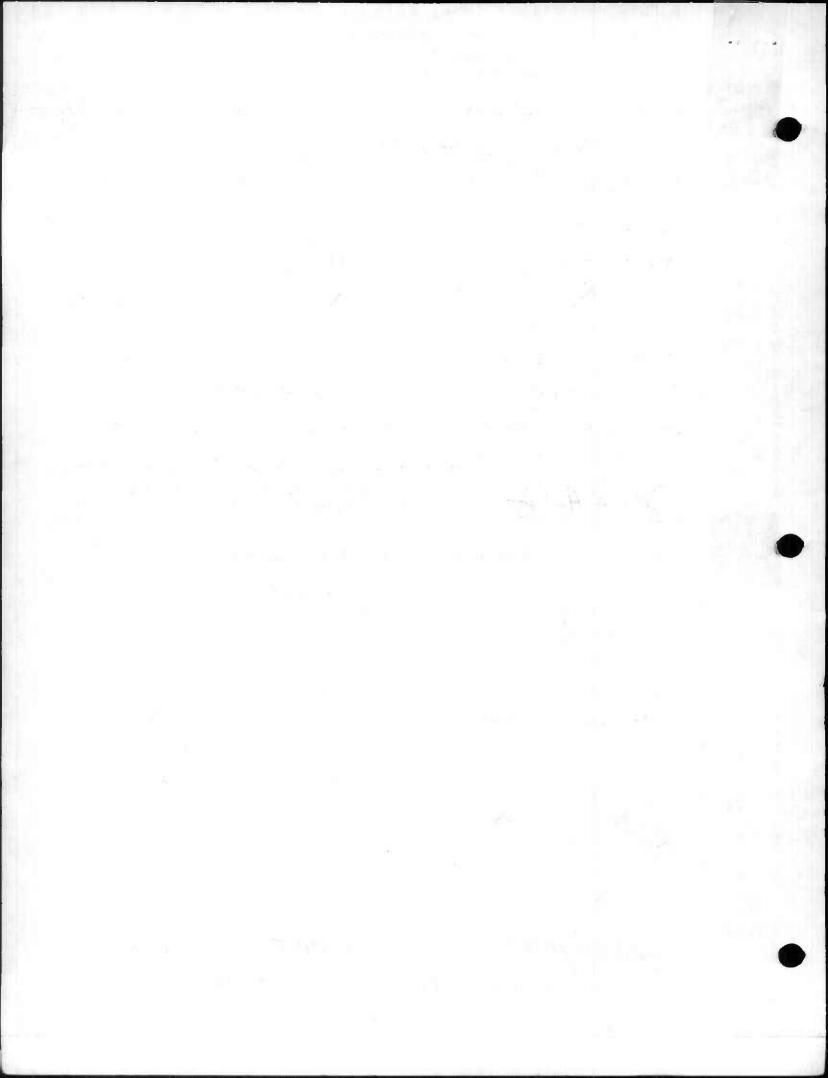
1 Yes 2 No

28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete)

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

2 Knoll DV. ColubrA MD.

32. Registrar's Signature wha Davidson-Randott MAR O



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1 Decedent's Name (First Middle I ast 2. Date of Death Day **Physician** February 27, 1998 8:20 AM MARGARET MARY DUMLER LEHR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number, Examiner HOLLY HILL MANOR Baltimore County Stoneleigh If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Yeer) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 5. Social Security Number **Funeral** Months Days 1□M 2♥F Yrs. Sept 8, 1904 **Director** 93 Maryland 215-48-8509 Usuel Residence of Decedent with the Marylend 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or flems 23s or 28s-4 show traumatic event, the Madical Examinat must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore County Stoneleigh 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "netural", or items 23a and Injury or other traumatic event, the Medical Englishments. 21212 USA 531 Stevenson Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: P White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Occupational Therapist Ass't Medical 10th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Weiman George Henry Dumler Cecilia 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3833 Dance Mill Rd., Phoenix, MD 21131 Margaret C. Lins (Daughter) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Grdns 3/2/98 Timonium, MD 21093 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Figural Savia 22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory afrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificete be axecuted ed by the attending physician end detached for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t Mollitus 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24e. Wes en autopsy performed? Completed been completion of cause of death? certificata has 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this funeral 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital After s after death.

I Director: After in by the funer

To the Hospital or within 24 hours at To the Funeral D

State Registrar

29b. Signature and title of certified Sicion

29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Marc Sokolow, 301 St. Paul Place, Suite #301, Baltimore, MD 21201 M.D.

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

31. Dete filed (Month, Dey, Year) MAR 0 3 1998

3 ☐ Suicide

29a. Certifier

edical

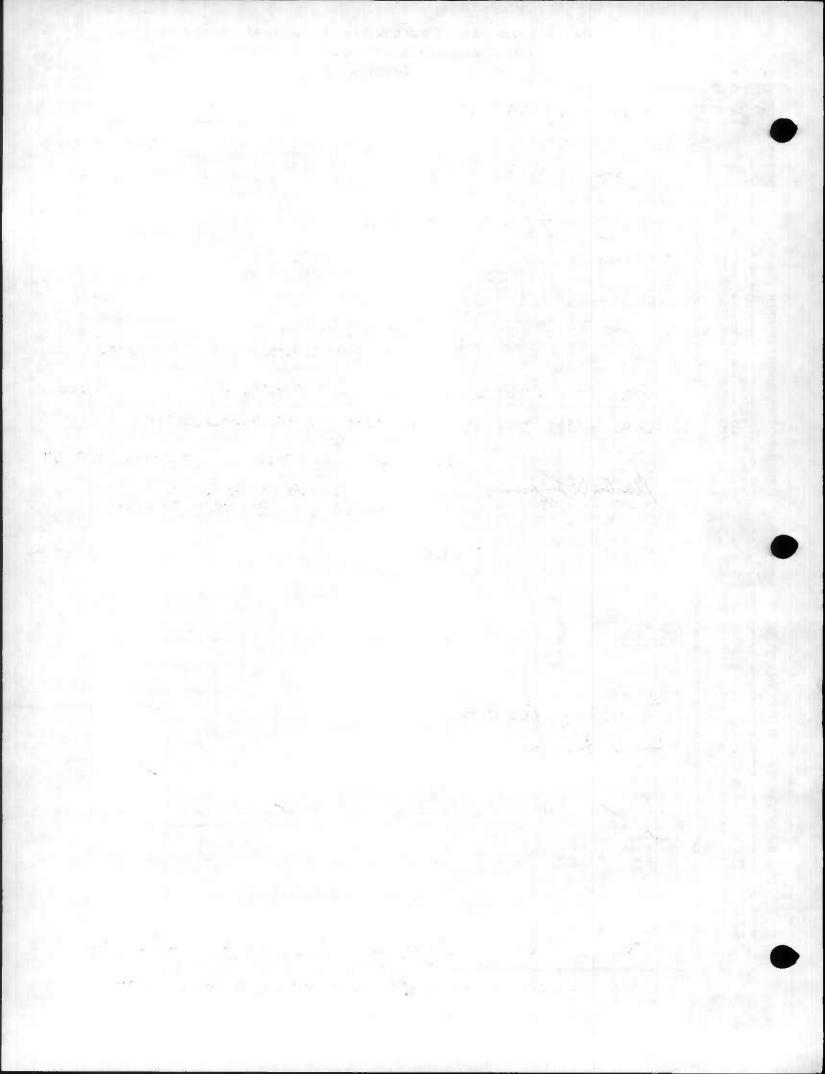
4 ☐ Homicide

(Check only

6 Could not be determined

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death February 25, 19 48 **Physician** Lillian Mutchnik 6:00 am /Medical 4a. Fecility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Sinai Hospital Baltimore 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC 24, 1900 7. Age (In yrs. lest birthday) 9. Birthplaca (Stata or Foreign **Funeral** Days Hours 10 M 20 F 214-68-0185 97 RUSSIA Yrs. Director Usuel Rasidance of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show treumstic event, the Medical Examiner must be notified at BALTIMORE 1 Yes 2 □ No Funeral Director 10f. Zip Coda 21215 10e. Street and Number 5804 GIST AVE. 10g. Citizen of What Country? USA items 23e Peges 1 and 2 should be filed within 72 hours after deeth nent of Health end Mental Hygiene. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 [XNo If Yas, Giva Yaar or Detas: 11 Maritai Status Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 ☐ Navar Merried 2 ☐ Married 21215-0020 6 þ 1□ Yas 2□ No Widowed 4 □ Divorced Specify: WHITE "naturel", Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Dacedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) OWN HOME HOMEMAKER Baltimore, Maryland 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middla, Maldan Surname) Be h end Mental h BARNEY RUDOW RACHEL UNKNOWN 19e. informent's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, State, Zip Code) Department of Health elimportant: if Item 27 la any Injury or other traconce. BALTIMORE, MD MELVIN MUTCHNIK (SON) 5804 GIST AVE. 20b. Placa of Disposition (Nema of camatary, cremetory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) SHOMREI HADATH VE TZEMECH SEDEK 3/1/98 ROSEDALE, MD 21. Signature of uneral Service Lightness 22 Nama and Address of Facility BROS., INC. Part 1. Enter the disasse, or complication; that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one coor on each line. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 Approximata Intervel Between Onsat and Death **Physician** a congestive heart failure b is chemic heart disease /Medical Immediata Causa (Finel disease or condition rasulting in deeth) Examiner Examiner years The law requires that the death certificate be executed Sequantially list conditions, if any, laading to Immadiata causa. Enter Undarlying Causa (Diseesa or injury that initiated events rasulting in daath) Last pue Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? chronic renal insufficiency 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evailable prior to complation of cause of death? Be Completed chronic obstructive pulmonary disease 24a. Wes en eutopsy performed? aortic stenosis 1 ☐ Yes 2 No this certificate Attanding Physician: 25. Was casa raferred to medical axeminar? 26. Placa of Daath (Check only ona) Hospitai: 1 Malinpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Certification: To 1 ☐ Yas 2 No nours after death.

neral Director: After this or filled in by the funeral dii 27. Mennar of Death 28e. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 1 Natural 2 Accidant 5 Panding Invastigation 1 ☐ Yas 2 ☐ No

Division of Vital 6 To the Hospital o within 24 hours af To the Funeral D completely filled i

> State Registrar

Medical

31. Data filed (Month, Day, Yaar) MAR 0 3 1998

29b. Signature end title of certifier

3 Sulcida

29a, Cartifian (Check only one)

4 ☐ HomicIda

6 Could not ba

30. Name end eddrass of person who completed cause of death (Itam 23a) (Type, Print) Maria Prince, sinai Hospital, 2401 W. Belvedere Ave., Baltimore MD ZIZIS

32. Ragistrar's Signatura Julia Davidson-Randell

28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)

Cartifying Phyalcian: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

281. Location (Street and Number or Rurel Routa Number, City or Town, Stata)

AS2402321MP9522 February 25, 1998

29d. Date signed (Month, Dey, Year)

a notified of Spring formations.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death

2	1	o co	P	2	2	2	
). 	in/Medical Examine	Medical Certification: To Be Completed by Physician/Medical Examiner	To Be	Certification:	Medical	
permit. Pages 1 Department of H Important: If iter any injury or off 9008.	Physician /Medical Examiner	ordificate be executed and and use es the burial transit	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death. To the Funeral Director: After this certificate has been signed by the ettending physician completely filled in by the funeral director, page 2 should be deteched for use as the burial transit	nysician: vis certific	To the Mospital or Attending Pr within 24 hours effer death. To the Funeral Director: After th completely filled in by the funera	the Hospit thin 24 hour the Funera mpletely fill	F358
Baltimore		ox 68760,	Division of Vital Records, P.O. Box 68760,	of Vita	Division o		

1. Decedant's Name (First, Middla, Last) 3. Time of Deeth **Physician** MURCHISON MABEL LORAINE Feb 20,1998 01:33am /Medical 4e. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING PRINCE GEORGES 5. Social Sacurity Number If Undar 1 Year If Undar 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1□ M 20 F Yrs. JULY22 Director 1909 LURAY, 579-03-7807 89 Usual Rasidance of Decedan 10a Stata 10b Counts 10c. City. Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at the Maryta 1√2 Yas 2 No Director MD PRINCE GEORGES KENSINGTON 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3514 DECATUR AVENUE 20895 U.S.A. Funeral 12. Wes Dacedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14 Rece - American Indian Black, Whita, atc. filed within 72 hours after. Hygiene. Ither than "natural", or itse 1 Yas 2 No If Yas, Giva Yeer or Datas: 1 ☐ Navar Marriad 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: à 3 Widowed 4 □ Divorced BLACK Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry DEPARTMENT Elamantary/Secondary (0-12) College (1-4or 5+) 12 ACCOUNTANT U.S. ARMY 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Meidan Surnama) 1 and 2 should be fill fealth and Mental H m 27 is marked oth Be **EDWARD** GREEN **ELIJHA** 2 JASPER 19a. informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, State, Zip Coda) MARIA KENNEDY 3514 DECATUR AVE. KENSINGTON, MD 20895 Oa. Mathod of Disposition 20b. Place of Disposition (Neme of cematary, cramatory or other pleca) 20c. Location - City or Town, Stata 1 ☐ Burial 2 【Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 24-98 BELTSVILLE, MD 21. Signatura of Funaral Service Licen 22. Name end Addrass of Facility TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST. NW WASH. DC 23a. Part1. Entar the diseesa, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Multi OLGAN MILURE

Dua to (oras a consequence of): mmediata Causa (Final diseasa or condition rasulting in death) Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaase or Injury that Initiated events resulting In daath) Last Due to (or es a consequance of): Due to (or as a consequence of) ev MO art If. Other significant conditions contributing to death but not rasulting in tha undarlying causa givan In Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings aveilable prior to complation of cause of daath? 24a. Was an autopsy performed? 2 0 No 1 ☐ Yes 1 TYas 2 No 25. Was casa rafarred to medical 26. Pleca of Deeth (Check only ona) axeminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 7. Menner of Deeth 28a. Dete of Injury (Month, Day Yaar) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Panding Investigation Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be datemined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, straet, fectory, office building, atc. (Spacify) 4 - Homicida To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian 9b. Signatureyand titia of certifier 29d. Data signed (Month, Day, Year) 29c. License number Feb 20,1998 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 3904 Cleveland-St Kensington Md 20895 Buda-Okreglak, Edwarda MD 32. Ragis rays Signatures 31. Data filad (Month, Day, Year) State MAR 0 3 1998 Registrar

ANYOUR AND THE RESERVE AND A RESERVE ANY 98-0954-510

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

BREENA
MCDONALD

State of Maryland / Department of Health and Menta	I Hygiene	20	0	p	fr-m	1
Certificate of Death	Reg. No. "	70	U	0	C	

Physician
/Medical
Examiner

Director

Funeral

by

Completed

Be

2

Examiner

Physician/Medical

by

Completed

Be

To

Certification:

edicai

3. Time of Death

Funeral

Director

with the Marylenc ir than "natural", or items 23s or 28s-f show the Medical Examiner naint be notified at death

permit. Peges 1 and 2 should be filed within 72 hours effer begornment of Health and Mentel Hygiene. Important: if Item 27 is merked other than "naturel", or itel any highry or other traumatic event, the Medical Examination altimore, Maryland 21215-0020

Physician /Medical Examiner

and physician a USB 3 peen The law page 2 s certificate has Physician: this funeral After Attending death. ofter deat Director: 2 24 hours efter Funeral Dire letely filled in b ò Hospital

Division of Vital Records, P.O. Box 68760.

2. Date of Death 1 Decedent's Neme (First, Middle, Last) Month BREENA JUSTINE McDONALD **FEBRUARY** 24,1998 9:43A.M. 4b. City. Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE CITY If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1□M 2XF Months Days Yrs 213-51-9385 6 OCT.18,1997 MARYLAND Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MD CITY BALTIMORE CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6209 SHIPVIEW WAY 21224 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② Who If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14 Rece - American Indian. 11. Meritel Status Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) N/A N/A N/A 18 Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) ROBERT LEE MCDONALD CHRISTINE RISER 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE RISER/MOTHER 6209 SHIPVIEW WAY BALTIMORE, MD 21224 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removel from State CARMEL CEMETERY 2/28 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) CHARLES S. ZEILER & SON, INC. 21. Signatuperof Funeral Service Licensee 6224 EASTERN AVENUE BALTIMORE, MD 21224 to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it failure. List only one cause on each line. Approximate fntervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mes to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting In death) Last Due to (or es a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

25. Was cese referred to medical 1⊠ Yes 2□ No 27. Manner of Deeth

5 Pending investigation 6 Could not be determined

Hospital: 1 Inpatient 28e. Dete of Injury (Month, Dey Year)

2XER/Outpetient 3□ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. fnjury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

26. Piece of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2XX Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

(Check only one) 29b. Signeture end title of certifier

1 Natural 2 Accident

3 Suicide

29a. Certifie

4 Homicide

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year)

FEBRUARY 25, 1998

2 No

neckus ny 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

HEDDORE U.K.n ^{'3''}1998

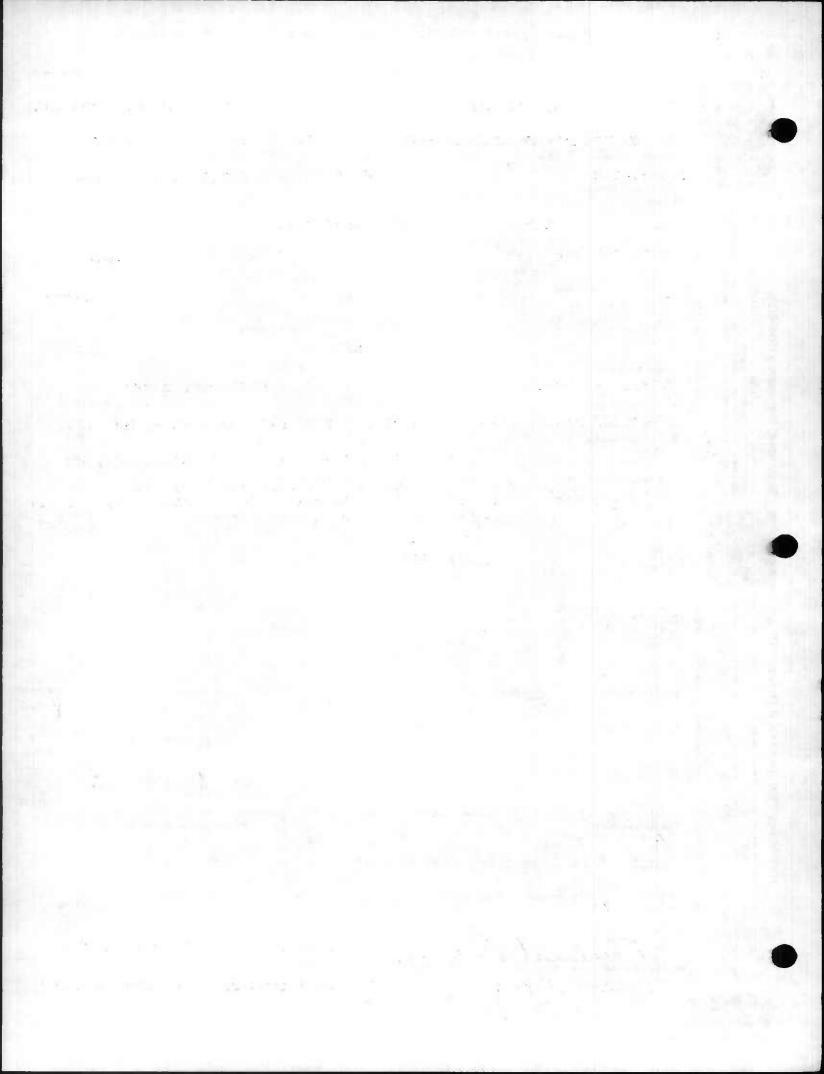
32 January Signature Pandall

111 Penn Street, Baltimore, Maryland 21201

State Registrar

completely

within 2 To the



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death Day HATTIE FEBRUARY 26,1998 MCNEAL 6:50am 4e Fecllity Nema (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Deeth Ravenwood Rehabilitation Baltimore Birthplace (Stata or Foraign Country) If Under 1 Yaar 8. Data of Birth (Month, Day, Year) 05/06/1891 5. Social Security Number 7. Aga (In yrs. last birthday) Days Months Hours 1 □ M 21X F 185-09-7015 106 Yrs. Usual Rasidance of Dacedant 10d. Insida City Limits 10b. County 10c. City, Town or Location MD Baltimore 1 TYas 2 No 10g. Citizan of Whet Country? 10e. Street and Numbe 10f. Zip Code 501 W. Franklin Street 21201 U.S.A. 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No 11. Merital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yas 2 No Specify: If Yas, Giva Yaar or Dates: 3 ₩ Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantery/Secondery (0-12) Collaga (1-4or 5+) In home Domestic 6th 18. Mother's Nama (First, Middla, Maiden Sumerna) 17. Fathar's Nama (First, Middla, Last) Richard Williams Anner Maden 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 501 W. Franklin Street, Balto., MD Ellen Omoshebi. AS 20b. Placa of Disposition (Nama of Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition cematary, cramatory or other placa) ₩ Burial 2 Cremetion 3 Removal from State LionCemetery 3/2/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Lic LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immadiate Ceusa (Final Cardio Vascular Disease disaasa or condition resulting In death) Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Diseese or Injury that Initiated avants rasulting in daath) Last Due to (or as a consequance of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting In the undarlying causa givan in Part i. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy 1 □ Yas No 1 Yas 2 No 25. Was casa rafarrad to medical examinar? 26. Plece of Daath (Check only ona) Othar: Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) Netural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant

physicien and the buriel-transit The law requires that the death certificate be axecuted Box 68760, signed by the et Division of Vital Records, P.O. been : page 2 : certificete in or Attending Physicien: T sate death. Orector: After this certificet of in by the funaral director, pa to the Hospital ovithin 24 moust at

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Haulth and Mentel Hygiene. Important: if them 27 is marked other than "natural", or them 23a or 28a-1 showing Injury or other traumatic event, the Manuelland Control of the Contr

Physician /Medical

Examiner

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edical Certification: To

6 Could not be 3 ☐ Suicida

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceusa(s) and manner as steted.

2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the causa(s) end menner steted. 29a. Certifier

29b. Signature and title of certifier

MAR 0 3 1998

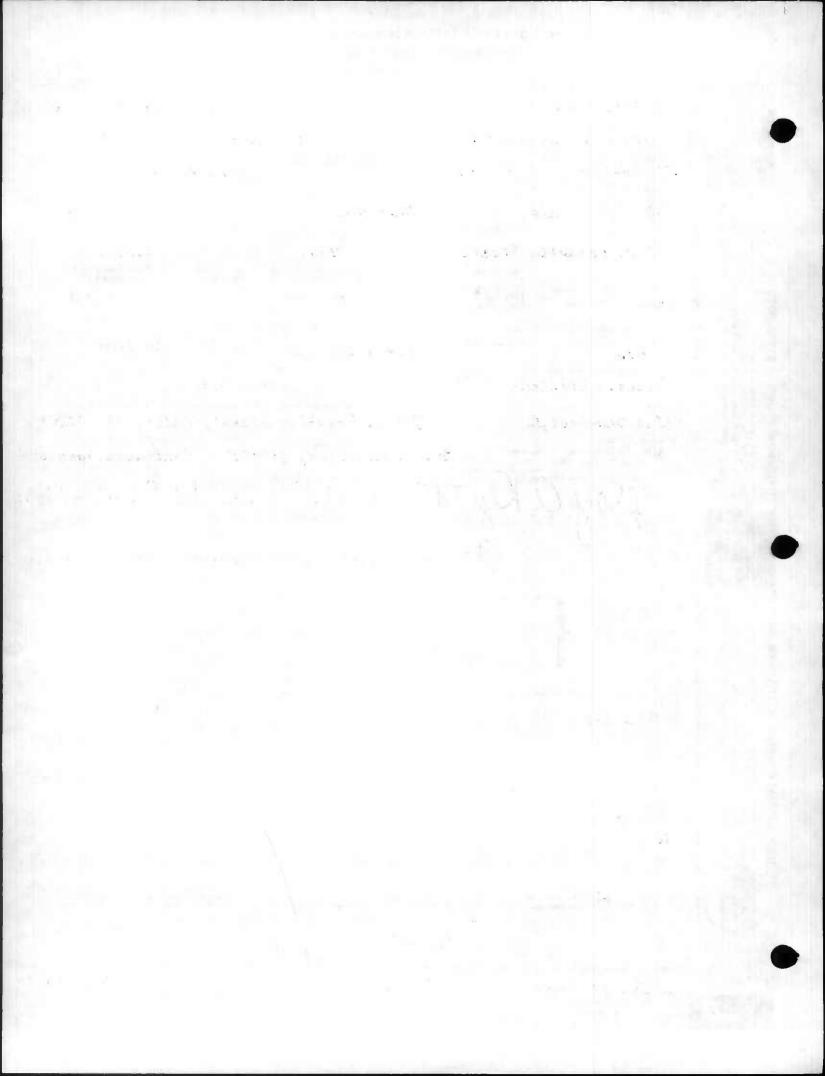
29c. License number 29d. Date signed (Month, Day, Year)

26

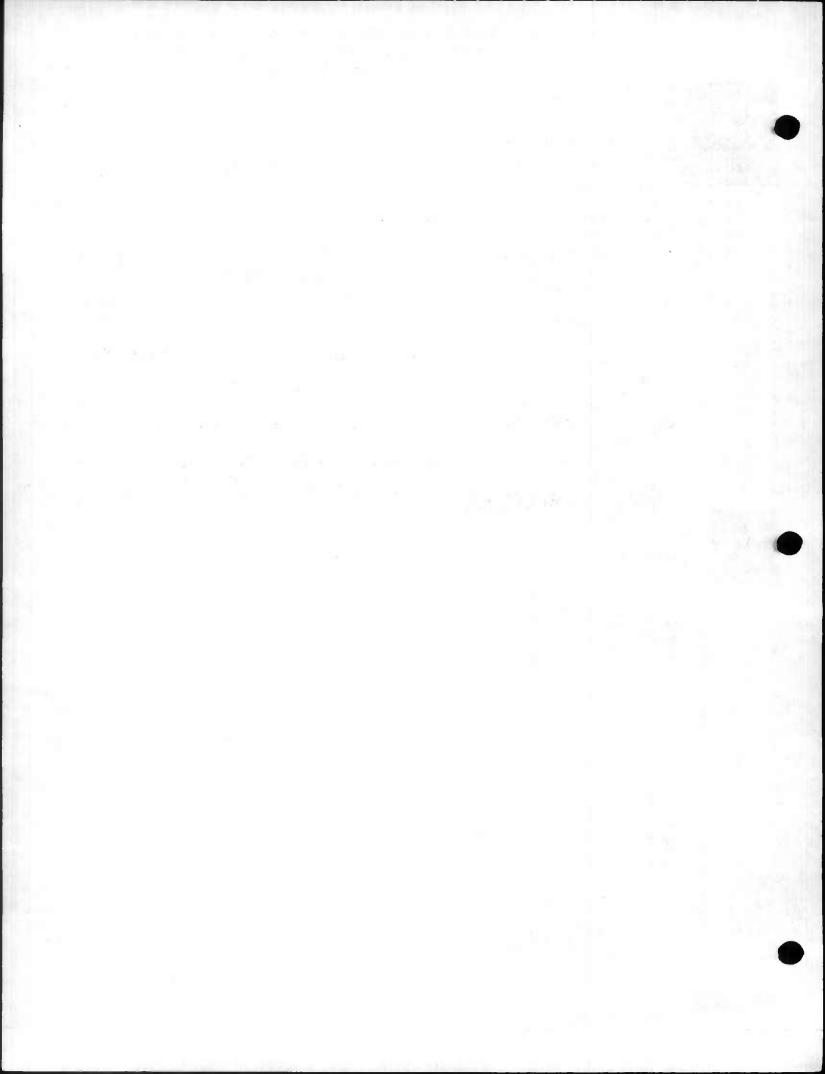
30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)

Entan Steer, Suite 407 bathmore, MD 21201 Tyoten Pari khus 31. Date filed (Month, Day, Year)

State Registrar

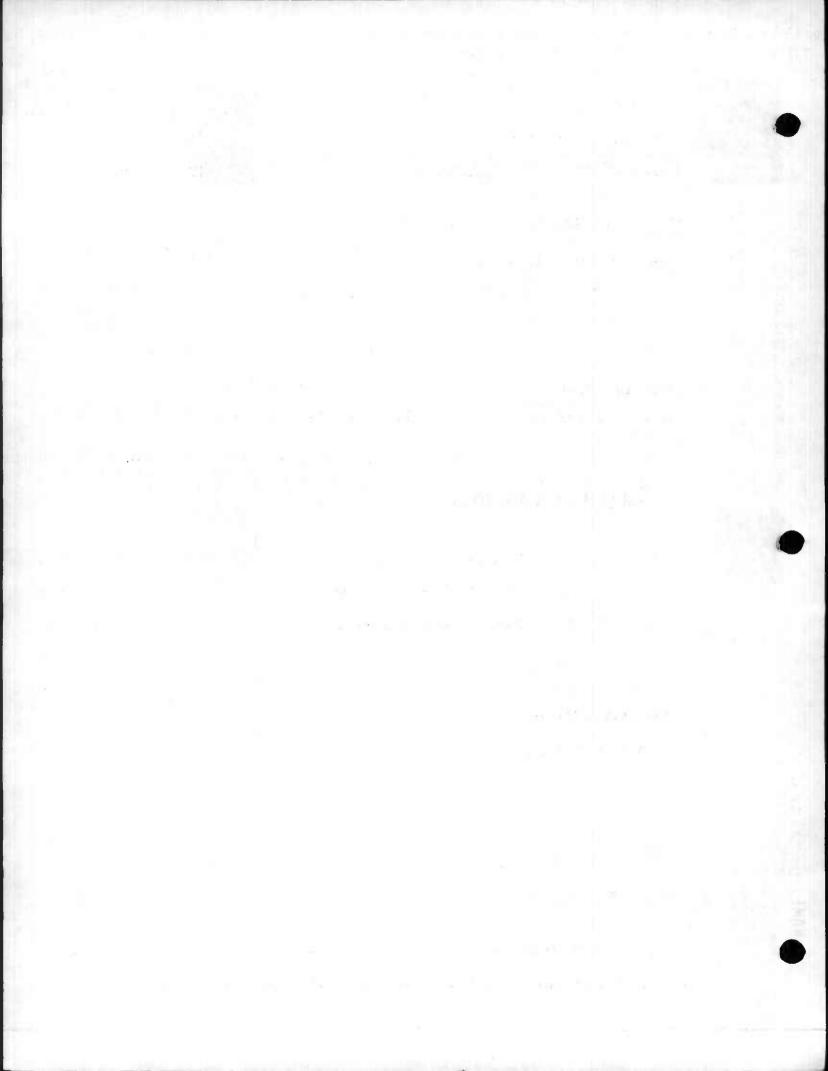


Jury or other traumatic event, the Medical Examinet must be not seen show and long or other traumatic event, the Medical Examinet must be not seen and long or other traumatic event, the Medical Examinet must be not seen and long or other traumatic event, the Medical Examinet must be not seen as a long or other traumatic event, the Medical Examinet must be not seen as a long or other traumatic event and long or	Usual Residence of Decedent 10e. State 10b. County MD n/a 10e. Street end Number 1236 Haverhi 11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g Elemantery/Secondary (0-12) 12 17. Father's Neme (First, Middle, Leter Edward Smith 19e. Informant's Name/Relationship	wski give street end number) 11 Rd. Sex 7. Age (III) 10 M 20 F 76 11 Rd. 12 Was Decedent Eve Armed Forces? 1 Yes, Give Yes, Give Yes, Give Yes, Give Yes, Give Yes, Give Server or Dates:	1	ore 10f. Zip Code 212	Hours Min.	8. Date of Bir (Month, De 8/17)	1 1 998 1 1 998 1 4c. County on / a th	9. Birthplace (State or For Country) Maryland 10d. Inside City L
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evament for nothing any injury or other traumatic event, the Medical Evament must be nothed as once. To Be Completed by Funeral Director	1236 Haverhi 5. Sociel Security Number 214-18-6876 Usual Residence of Decedent 10e. State 10b. County MD n/a 10e. Street end Number 1236 Haverhi 11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest g Elemantery/Secondary (0-12) 12 17. Father's Neme (First, Middle, Leter Edward Smith 19e. Informant's Name/Relationship	11 Rd. S. Sex 1 M ZN F 7. Age (II) 7. Age (III) 10 11 Rd. 12. Was Decedent Eve Armed Forces? 1 Yes, Give Year or Dates: Education grede completed)	Baltimo	cation Ore 10f. Zip Code 212 Was Decedent of I	Baltin Hunder 24 Hrs Hours Min.	8. Date of Bir (Month, De 8/17)	n/a°	9. Birthplace (State or For Country) Maryland 10d. Inside City L
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Important: If any injury or gode.	Edward Smith 19e. Informant's Name/Relationship	st)	Nurs	e's Aid		me (First, Middle	Heal: , Maiden Sumeme	th Care
Important: If any injury or gode.	19e. Informant's Name/Relationship					Harris		-,
Important: If any injury or once.		(Type, Print)	19b. Mailin	g Address (Street	t end Number or R	ural Route Numb	er, City or Town, S	Stete, Zip Code)
Important: If any injury or once.	Walter L. Gove	er, Sr.	1236	Haver	hill Rd	. Balti	more,	MD 21229
	20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3		20b. Plece of Dispos cemetery, cren	sition (Neme of netory or other ple	oce)	Date	20c. Location - 0	City or Town, Stete
	4 Donetion 5 Other (Spec	cify)	Cedar H	ill Cen	netery	3/2	Brookly	yn Park
	21. Signature of Funeral Service Lic	Induce	13	Name end Addre 28 Sulp	ess of Fecility An phurspri	mbrose ing Rd.	Funeral Arbuti	l Home, In us MD ₂₁₂₂₇
miner ខ	Immediate Cause (Final diseese or condition resulting in death)	e. Due	Lymple to das a conseq	uence of):				Approximete Intarval Betwee Onset end Dea
s the buriel-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	Due	to (or as a conseq	uence of):				
E Su	that initiated evants resulting in deeth) Last	Due d.	to (or es e consequ	uence of):				
ysicia	Part II. Other significant conditions	contributing to death but no	ot resulting in the ur	ndarlying causa gi	iven in Part I.	23b. Did	tobecco use con	tributa to the cause of d
20 70						10	Yes 2□ No	3 □ Probably 4 ☑ Uni
page 2 should Completed							an autopsy prmed?	24b. Were eutopsy findi available prior to complation of ceus of deeth?
rector, page						1 🗆	Yes 2 No	1 ☐ Yes 2 ☐ No
director,	25. Was cese referred to medical examiner?	Hospital:		_ 0	hor:	eth (Check only		
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tha ca	2 Accident Investigati 3 Sulcide 6 Could not 4 Homlcida determine	be one Blace of Injury	At home, farm, stre	M 1	Yes 2 No	28f. Location (City or To		er or Rural Route Number
	29a. Certifier 1 Certifying F	Physician: To the bast of maminer: On the basis of exa	y knowledge, daath	occurred at tha ti	ima, data and place	e, and due to the	cause(s) end mer	nner es steted.
Mediat	one)	and manner stated	·			med at the time,		
2	OOL Clarature Live A	n 1	100	29c. Licen:	se number		hannia ateff boy	
3	29b. Signeture and title of certifier	Chenez	for h	D	-4052	1	Februa	1 (Month, Dey, Year) by 27, 1998 Suite 305 21229



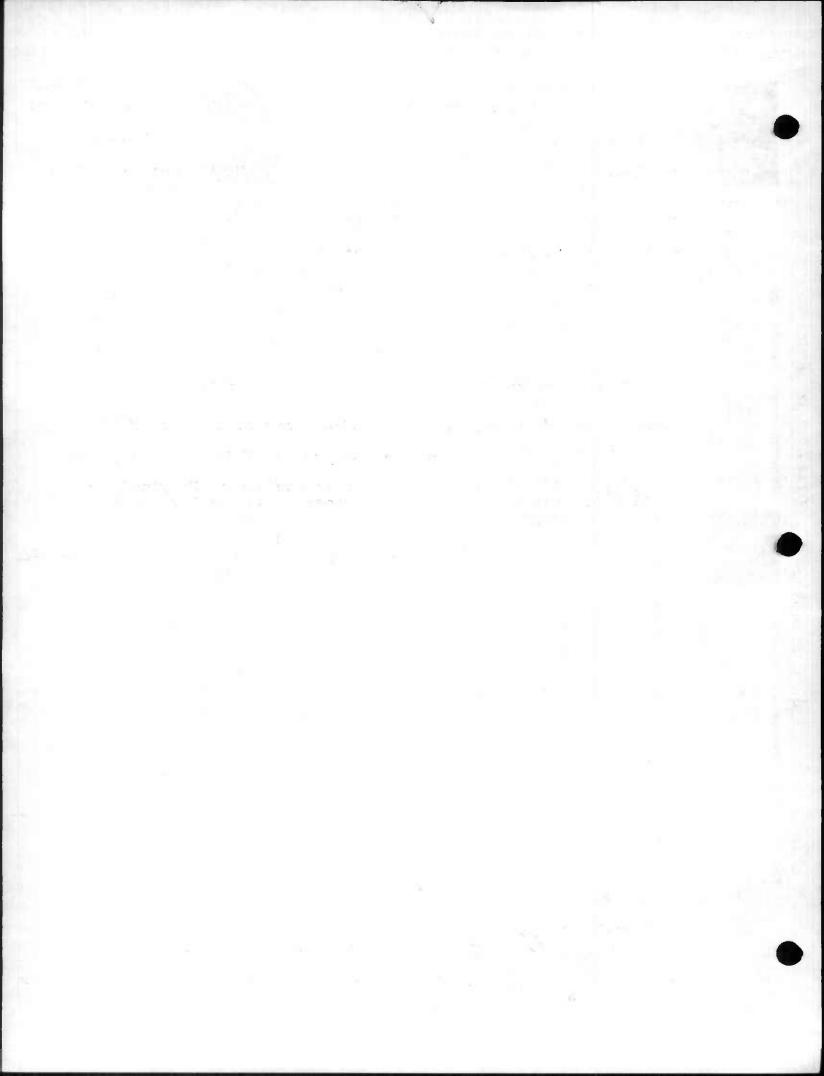
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/Medic Examin	al	Carolyn S. M	anev						Month	Dey	Year	40 -
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0 8	ᄒ						1227	7		10g. Citizen of United		
al.	St. Agnes Ho 5. Social Security Number 219-40-1271 Usuel Residence of Decedent 10e. Stete 10b. County MD Balti 10e. Street end Number 2809 Pennsylv 11. Meritel Status 1 Never Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest of Specify only highest		nia Ave. 12. Wes Decedent Armed Forces' 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	?	S. 1	3. Was Dec If Yes, sp	edent of H ecify Cubi		Specify Yes or Nerto Rican, etc.)	No- 14. Ra	ce - American ck, White, etc y: Whit	Indian,
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within 24 hours after death. To the Funeral Director? After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Pleca of In building, et	ury - At ho c. (Specify	me, ferm,	street, facto	ry, office		28f. Location City or To	(Street and Numi own, State)	ber or Rurai R	oute Number,
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		Bet J. 30. Name and address of person who	Morton,	M. C)		D08	949		February	25, 1	998
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uneral Pirector		5. Social Security Number 214–22–8987		M 2₩ F	7. Aga (In yrs. 86	last birthday) Yrs.	If Undar 1 Months E		Hours Min.	8. Data of Birt Month Da AUG 05	, 1911	9. Birthpla Country West	ca (Stata or Fore Virgini
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dotte de	e C	17. Fathar's Nema (First, Mide Charle		Harb	ert		Imitting Clerk 18. Mothar's Nama (First, Middle, Maiden Surmema) Eva Shields Meiling Addrass (Street and Number or Flural Route Number, City or Town, Steta, Zip Coda) 13 E. Biddle Street Baltimore, MD 21205 Dete 20c. Location - City or Town, Stata Crematory, Inc. 03/02/98 Baltimore, MD 22. Nama and Addrass of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 not aniar tha mode of dying, such as cardiec or raspiratory arrast, Approximate intarval Batwaan Onsat and Death Consequence of): consequence of):						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** HATTHEWS, M.D. MARY MARCH 1998 /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not Institution, give street end number) 4c. County of Deeth **Examiner** Good Samaritan Hospital Baltimore N/A If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months Days Yrs. Director 83 241-12-3574 Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be northed at Director 1 ☐ Yes 2 X No Md. Baltimore Glenarm 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 11630 Glenarm Rd. 21057 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ ∑No If Yes, Give Year or Dates: 11. Meritel Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Pediatrician 12 Pedriatics .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If Itam 27 Is marked other t jury or other traumatic event, to Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Matthews, Sr. Moddie Ellington 2 Joseph 19e. Informent's Name/Relationship (Type, Print) Nephew 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rev. Joseph C. Matthews, III 2466 Shawnee Lane Waldorf, Md. 20601 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. Hilltop Service Corp. 3/04/98 Towson, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 23a. Pern. Enterthe disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Ceuse (Final UROSEPSIS disease or condition resulting in deeth) Examiner Examiner KETOTIC OFABETIC HYPEROSMOLAL Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Box 68760 PNEUMONIA Physician/Medical The law requires that the deeth certificate the Due to (or es e consequenca of): use as P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uea contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown . INSYLIN DEPENDANT STABETES MELLITUS Records, ģ page 2 should be 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? CVA 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 1 Yes 2 No 1 Impatient 2 ER/Outpetient 3 DOA this 27. Menner of Deeth 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred After Division 5 Pending investigation 1 Naturel s efter deeth. 1 ☐ Yes 2 ☐ No the 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours e □ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier completely (Check only one) 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) P-11389 MARCH, 1, 1998 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

6935 DONACHIERD & GALTIMORE - MO 21239

State Registrar ZOWHBI

12. Register's Signeture The Davidson-Randell

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 98 KMary 1 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ALTIMONE WY51W4 LOTIEN Home If Under 1 Year 7. Age (In yrs. last birthday) 78 Yrs. If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplaca (Stete or Foreign Country) 5. Social Security Number 1 □ M 25 P Months Days Hours Min 218-18-1740 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside Cltv Limits 1 Yes 2 No MID 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14. Raca - American Indian, 21206 5009 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 → Specify Blace 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Labore, 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) UNK UNK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BATIMON MB. 21201 Artie Shaw. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Luns downe, MD Donation 5 Other (Specify) spert P. WYLie 7/H PA 21. Signature of Funeral Service Licensee 2 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. 71515. ani monith Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to b Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Whiknown 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show a notified at

Director

Funeral

þ

Completed

Be

Peges 1 and 2 should be filed within 72 hours after death with the Meryland nent of Health end Mentel Hygiene.

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23s or traumstic event, the Modical Examiner must be re-

Item 27 is other tra

permit. Peges
Department of
Important: If It
any injury or c

physician end s the buriel-transit

Examiner Physician/Medical þ Completed Be

Medical Certification: To

1 Yes

27. Manner Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homictde

ZEMO

29b. Signature and title of cartifie

31. Date fited (Month, Day, Year)

2 Medicat Exa

MAR 0 3 1998

The lew requires that the death certificete be executed signed by the e certificate hes b lirector, page 2 s Ittending Physician: death.

Division of Vital Records, P.O. Box 68760, 8 4

> State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Year) 5 Pending Investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 28h Time of 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2000

24a. Was an autopsy performed?

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

29d. Date signed (Month, Day, Year) 29c. License number

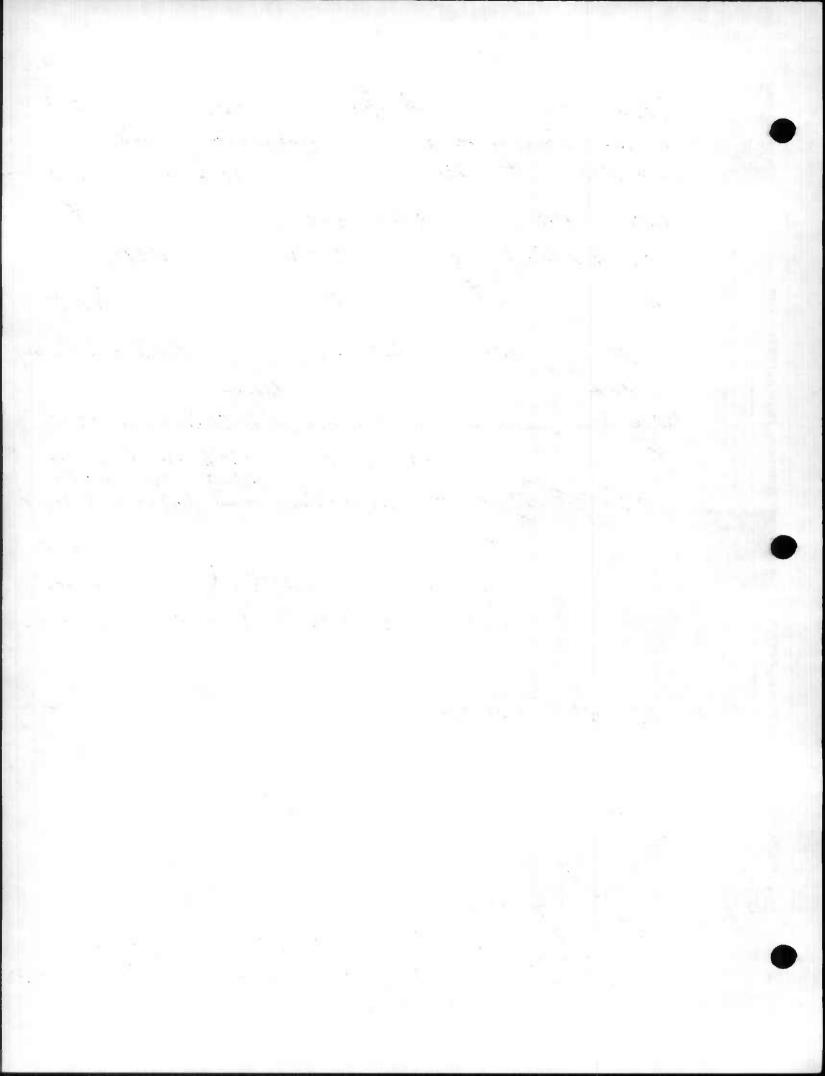
26. Place of Death (Check only one)

151 HOLABIRD A

24b. Were autopsy findings available prior to completion of cause of death?

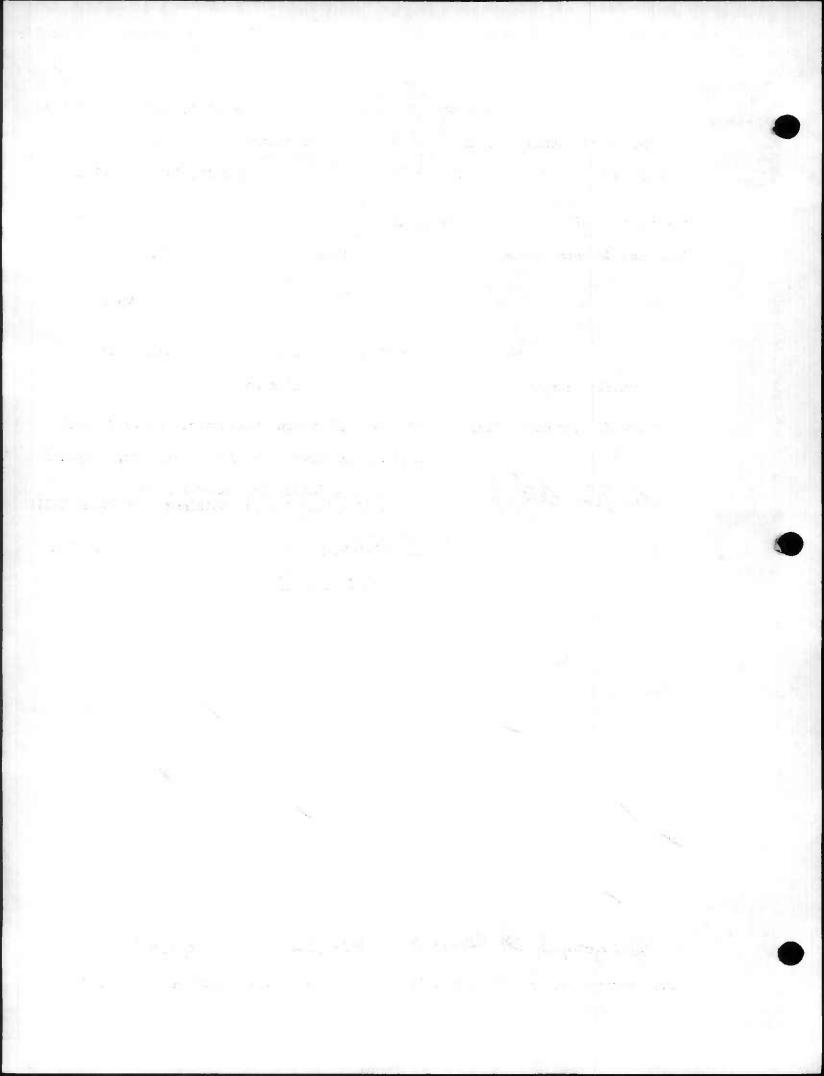
1 ☐ Yes 2 ☐ No

30. Name and address of per



State of Maryland / Department of Health and Mental Hygiene

							ficate of			leg. No.		
Physician		1. Decedent's Name	(First, Middle, La	ist)			2. Dete of Month				Yeer	3. Time of De
/Medic			John	n R. McG	reevy				March	1, 001998	1001	12:40p
Examir		4e. Facility Neme (If	not institution, giv	e street end number))			4b. City, Town, o	r Location of Deeth	Deeth 4c. County of Deeth		
		Long G	reen Nur	sing Cent	er			Baltimo	ore	N/A		
Funeral		5. Social Security Nu	imber 6. S	Sex 7. Ag			If Under 1 Year		s. 8. Date of Birth		9. Birthp	lece (State or F
Director		216-05-80 Usuel Residence of I	173	1⊠M 2□F	84	Yrs.	Months Days	Hours Mi	s. 8. Date of Birth (Month, Day Jun 19	, 1913	Mary	Tand
show	_	10a. State	10b. County			, Town or Locat		_			1	Od. Inside City L
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Depertment of Health end Mental Hygiene. Important: If items 23a or 23a-f show important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner main be not fred at once.	by Funeral Director	11. Maritai Status 1 ☐ Never Marrie 3 ☐ Widowed 4		12. Wes Decedent Armed Forces? 1 ☐ Yes XX If Yes, Give Year or Detes:	?		s Decedent of les, specify Cub		Specify Yes or No- into Rican, etc.)	Bied	ca - Americ ck, White, White	etc.
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nark nati	70											
Is r		19e. Informant's Ner	ne/Helationship (Type, Print)					Rural Route Numbe			
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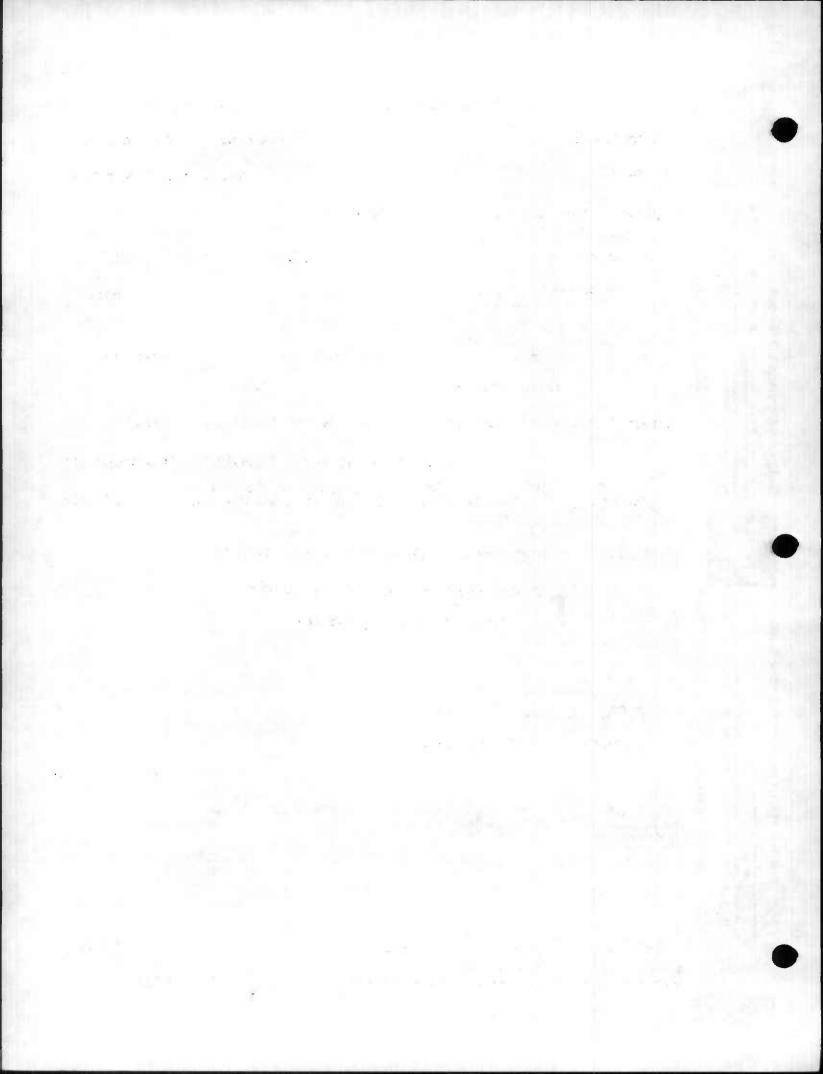


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey **Physician** Sarah Ann McKnight 1 a.m. 27,1998 Feb. /Medical 4b. City. Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner 4 Appian Way Pasadena Anne Arundel If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dev. Year) 5. Social Security Number Birthpleca (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1□ M 2⊠ F Months Deys 227-42-0041 Yrs. 63 Director March 29,1934 Maryland Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside Clty Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at Maryland Anne Arundel Pasadena 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4 Appian Way 21122 U.S.A.

14. Race - American Indian, Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Bleck, White, etc. 2 should be filed within 72 hours after one Mental Hygiena.
Is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 20 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiena. College (1-4or 5+) Elementery/Secondary (0-12) 12 Para Legal Legal Aid 18 Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Irvin Stevens Lula Brown 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) permit. Pages 1 end 2:
Department of Health or
Important: if item 27 is
any injury or other trau Donald G. McKnight Husband 4 Appian Way Pasadena, Maryland 21122 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. Feb. 28, 1998 Baltimore, Maryland 21. Signeture of Funerel Service Licenses 22. Name end Address of Facility McCully-Polyniak Funeral Home 23 rt. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. 3204 Mountain Road Pasadena, Maryland 21122 Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) · CHRUNC OBSTRUCTIVE /Medical LUNG Examiner Due to (or es e consequenca of) Examiner CONGESTIVE HE IRT buriel-transit Due to (or es e consequenca of) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest and certificate be axecu PRESSURE Br000 HIGH physicien Physician/Medical the Se USB Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 100 1 Yes 2 No 3 Probably 4 Unknown 2 ULCER DISEASE of Vital Records. À 24b. Were eutopsy findings eveilable prior to completion of cause of death? ELEVITED CHOLESTEROL 24e. Wes an eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 this funeral 28d. Describe how Injury occurred 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: sion 1 Neturel 5 Pending 1 TYes 2 No Investigation 2 Accident Director: 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homlcide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D35621 30 Neme end eddress of person who come eause of deeth (Item 23e) (Type, Print) 4191 MOUNTIN PASADENA, MD M.D

State Registrar 31. Dete filed (Month, Day, Year) MAR 0 3 1998

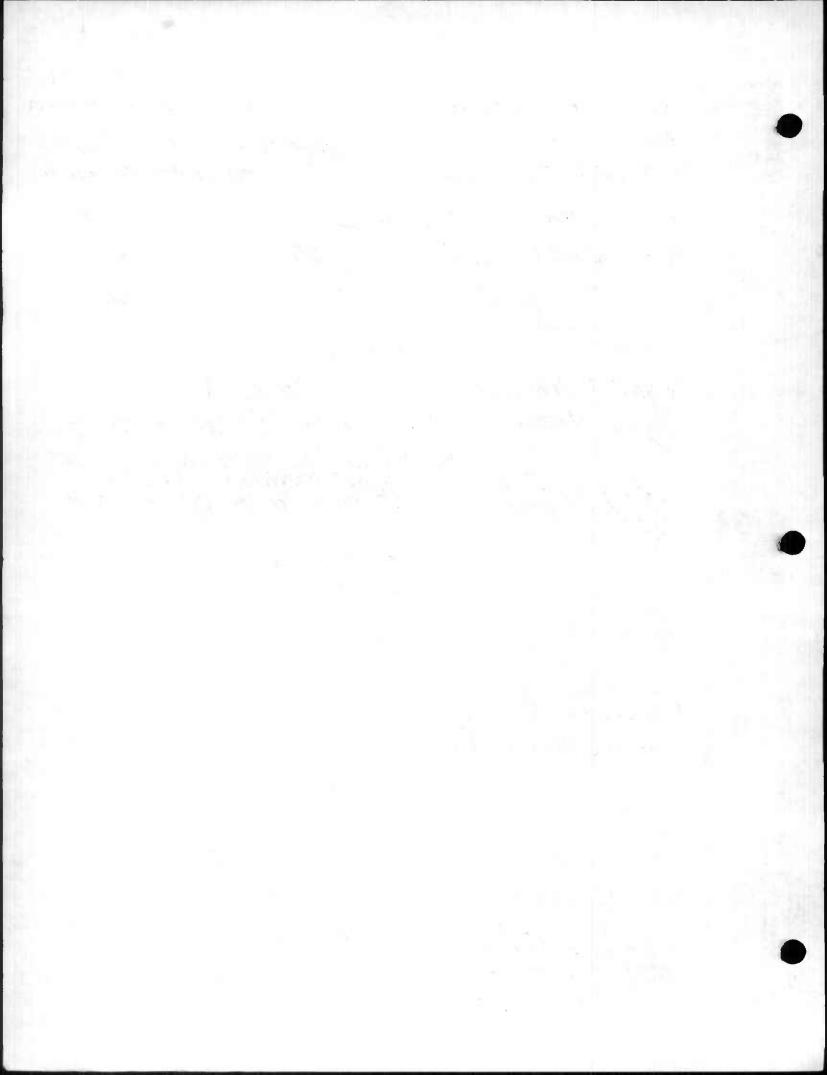
32. Registrer's Signeture Julia Davidson Randelle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		Reg. No. 98	56521
		1. Dacedent's Nama (First, Middla, Last)	2. Data of Das	ith	3. Time of Death
Physicia /Medica		Irvin A. Madden	Februa	Day Yaar	8 8:45PM
Examine		4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or L			0
		MARINER AGALTH GLENB	URVIB	Anna	Armost
Funeral		5. Social Sacurity Number 6. Sex 1 PM 2 F 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Data of Birth (Month, Day	Yaşılı 9. Bi	rthplaca (Stata or Foreign puntry)
Director		Usuel Rasidance of Decedant	MAR. 24	51935 11	ARYLAND
/land	1	10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits
Man,	to	MD N/A BALTIMONE			1 ☐ Yas 2 ☐ No
ith the Marylan or 28a-f show	ire e	10e. Street and Number 10f. Zip Coda		10g. Citizen of What C	ountry?
ath will	a le	760 DEACONAILL COURT 21225		U.5,A	
ter dea items	Funeral Director	11. Marital Status 12. Was Dacadant Evar in U,S. Armed Forces? 13. Was Decedant of Hispenic Origin? (St. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, atc.)	14. Race - Am Black, Wh	
020 urs after death with the Maryla al, or ttems 23s or 28a4 shor Exercises must be notified at	by Fu	1 Naver Married 22 Married 1 Yas 2 PNo 1 Yes 2 PNo Specify:		Specify: 93	inx
Ind 21215-0020 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28e-f show event, the Madical Examinat must be notified at		3 Wildowed 4 Divorced Yaar or Datas: 15. Decedent's Education 16a. Decedent's Usual Occupation		V	
215-C	Completed	(Specify only highast grada complated) (Give kind of work dona during most of work	king	16b. Kind of Businass	s/industry
212 d with giene.	E	Elementary/Sacondary (0-12) Collaga (1-4or 5+)		SHOE	
laryland 212 2 should be filed with and Mental Hygiene. Is marked other than aumatic event, than	Bec	17. Fathar's Nama (First, Middla, Lest) 18. Mother's Nam	ne (First, Middle,	Maidan Sumame)	
ylal buid b Menti Mente	2	WYATT F. MADDEN ANN	15 I	15/1	
		19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Straat and Number or Ru	ral Route Number	r, City or Town, Steta,	Zip Code)
or Health	-	20a. Mathor of Disposition 20b. Place of Disposition (Nama of	1. DA.	11, MD. 1	4225
Baltimore, semit. Pages 1 ar Department of Hea mportant: If them 2 my Injury or other page.		1 Buriai 2 Cramation 3 Ramovei from Stata cematary, crematory or other place)	Date 1	20c. Location - City o	r Town, Stata
Baltimo	-	4 Donation 5 Other (Specify)	12/18	XXXXX 15/00	wo MV,
Balt permit. Depart Import		21. Signature of Funeral Service Licensee 22. Name and Address of Parks of of Pa	HUNERA,	140ME_11	A
		JONE 11 Jane 270 FRODAILTON	1495 Y	n17, MD.	21229
	1	23a. Plant End of disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or heart feilure. List only one cause on each line.	or raspiratory ar	rast,	Approximata Intarval Between Onset and Daath
Physician /Medicai		Immediate Causa (Final			1/
Examiner		Immediate Causa (Final disease or condition rasulting In death) a. Carcinomatous S		•	2 Month
	je	b. Metastatie Colon	(proni	
and I-trains	Examiner		Care	More	1
		Sequentially list conditions, if any, laeding to immadiata cause. Entar Undartying Cause (Diseese or Injury			
68760, ficate be a physician a the buria	edicai	thel initiated events rasulting in daath) Last Dua to (or as a consequence of):			
20 00 00		d			
Box eath cer attendir	Physician/N				1
P.O. at the de d by the setached	hys	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.			e to the cause of death?
	by P	Prostate larcinoma	101	′es 2⊞No 3⊟F	Probably 4 Unknown
Vital Records, telan: The law requires the certificate has been signed rector, page 2 about be considered.	8	Ch - 12 0 6 1 0	24e. Wes	an autopsy 24b.	Wara autopsy findings aveilable prior to
S be s	plet	involve renal jailine	parror	med?	complation of causa of daath?
I Re lav	Completed	Dix hote Moll to Tage ?	1 🗆 Y	es 2 No	1 □ Yes 2 1 NO
lian: The		25. Was cese refarred to medical axaminar?	ith (Chack only or	na)	
Py Sp	<u> </u>	1 ☐ Yas 2 ☐ No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	oma 5 ☐ Rasid	ance 6 □Other (Spe	ecify)
ding P	00	27. Manner of Death 1 ► Natural 5 □ Panding 28e. Dete of Injury (Month, Day Year) 28b. Tima of Injury Work?	28d. Describe h	ow Injury occurred	
Vision Attending Attending Attending Attending Attending Attending	Icat	2 ☐ Accident invastigation 3 ☐ Suicide 6 ☐ Could not be 200 € Discontinuous formation of the country of the co	00/ 1		
Olive Direct	Certification:	4 Homicida 4 Homicida 4 Homicida 4 Homicida 4 Spacify)	City or Tow	treet and Number or F n, Steta)	ru <i>rai H</i> oura Num <i>ber</i> ,
	<u>a</u>	29e. Certifier Cartifying Physician: To the best of my knowledge, daath occurred et tha time, date end plece,	and due to the c	euse(s) end menner a	s stated.
RESER	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occur and mannay stated.	rred at tha time, o	lata and place, and du	a to tha ceuse(s)
5 T 60 m		29b. Signature end titla of certifier 29c. Licansa number		9d. Data signed (Mon	th, Day, Year)
		Mod SIFOMD DOZS	19	2-27	-98
4		30. Name and address of person who completed ceusa of death (Item/23a) (Type, Print)	1	Δ -	21226
U			ny to	n Auc	21626
State Registra	•	31. Date filed (Month, Day, Yeer)			
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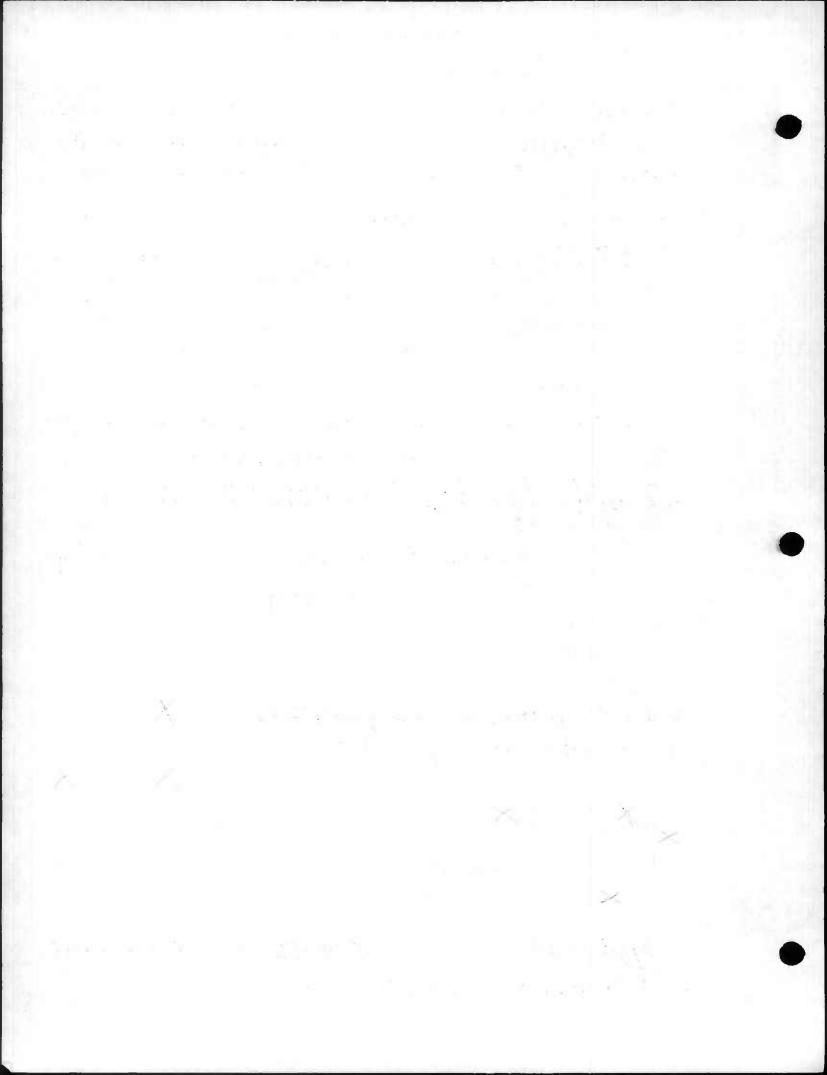


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Month **Physician** Bessie 0630 March 1998 02 /Medical 4a. Facility Nama (If not institution, giva street end numbar) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Hospital Sinai Baltimore Baltimore City if Under 1 Year If Under 24 Hrs. 8. Data of Birth
Machel Dave Hours Min. (Month, Day, Year) 5. Social Sacurity Number 6. Sex 7. Age (in yrs. last birthday) 9. Birthplace (State or Foreign 8, 1909 Maryland **Funeral** 1 □ M 2X F 89 Yrs. Director Feb. 213-34-6534 Usuel Rasidance of Decedant 10a. Stata 10b. County 10c, City, Town or Location 10d. insida City Limits Show r than "natural", or items 23a or 28a-f show **Funeral Director** 1√DyYas 2 No Maryland Baltimore 10e. Street end Number
The Wesley Home 10f. Zip Code 10g. Citizan of What Country? 2211 W. Rogers USA Avenue 21209 12. Was Decedent Ever In U.S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status filed within 72 hours after 1 Yas XXNo If Yas, Giva Yaar or Datas: 1 Naver Marriad 2 Married altimore. Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: by XDXWidowed 4 □ Divorced white Be Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highest grada complated) 16b Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) Collage (1-4or 5+) Homemaker In Own Home 8 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if item 27 is merked other any injury or other traumatic event, if 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Malden Sumeme) Andrew Jones Sarah 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) John Dunnigan 9019 Chateau Gay Ct. Baltimore, MD 21234 (Son) 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) Date 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramovel from Stata Lorraine Park Cemetery 3/4/98 Woodlawn, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Burgee-Henss Funeral Home, 21. Signetura of Funaral Service/License 3631 Falls road Baltimore, MD Den 21211 23a. Park. Entar the disease, or complications, hat caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition rasulting in death) /Medical Aspiration 10 days Examiner Sequentially list conditions, if any, leading to immediate cause. Enfar Underlying Cause (Disease or injury that initiated evants resulting in death) Lest P.O. Box 68760, requires that the death certificate be Physiclan/Medical 2 Dua to (or es a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? hypertension, Coronary aftery disease 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were autopsy findings available prior to chromic renal insufficiency, stroke 24a. Was an autopsy performed? complation of causa of deeth? 1 Yas 25. Was casa rafarred to medical axaminer? Be 26. Place of Death (Check only ona) 1 Yas 2 Other: 4 Nursing Homa 5 Residance 6 Othar (Specify) Hospital: 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA # 28c. Injury at Work? Medical Certification: 28b. Tima of 28d. Dascribe how injury occurred Attor Natural 2 Accident Attending 5 Panding invastigation 1 ☐ Yas 2 ☐ No death Director: 8 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) B after A 4 Homleida Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and place, and due to tha causa(s) and manner as stated.

2 Medical Examiner: On tha basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Cartifian (Check only one) withing To the F 29b. Signatura and title of certifiar 29c. Licansa number 29d. Data signed (Month, Dey, Year) AS2402321-RB9303 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Baltimore Behrens Hospital Sinai 31 Date filed (Month, Day, Year) MAR 0 3 1 32. Ragistrar's Speature Registrar

DHMH 16 Rev 6/95



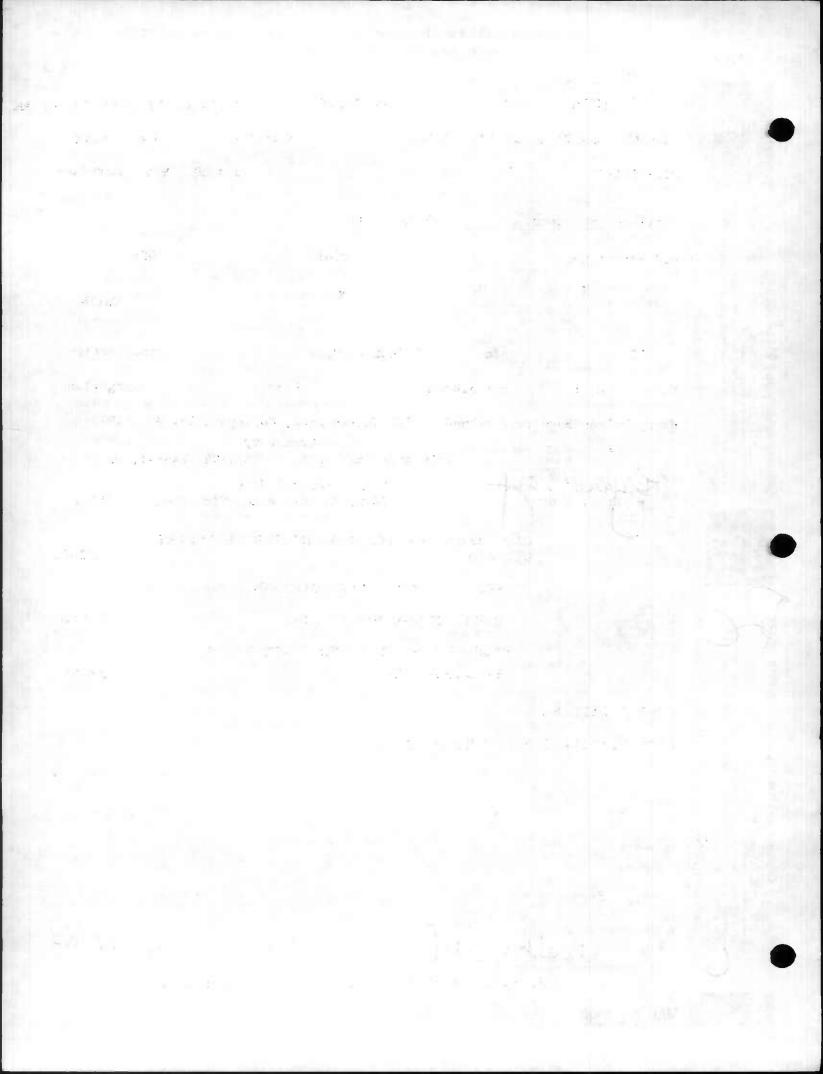
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Dey 27,1998 11:45 AM **Physician** NEWBERRY VIRGINIA ROSE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Jan 28, 1915 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Days Months 1□M 2⊠F Hours 212-05-1985 Maryland Director 83 Usual Residence of Deceden the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. inside City Limits ahow 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, in Modical Examiner must be notified at 1 ☐ Yes 2 No Directo Cockeysville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 21030 IISA Funeral 417 Warren Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. filed within 72 hours after (Hygiena. ther than "netural", or Ne 1 ☐ Never Married 2 ☑ Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Communications Telephone Operator 12 n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be filk framen of Haalth and Mental Hi tant: If item 27 is marked oth jury or other traumatic even Be Hutchinson Laura Slingerland 2 H. Earl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 417 Warren Road, Cockeysville, MD Harry Nelson Newberry/Husband altimore. 20b. Place of Disposition (Name of cemetery, cremetory or other plecerematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremetion 3 ☐ Removal from State pemit. Page Department of Important: If any injury or once. Baltimore Washington 4 Donation 5 Other (Specify) 3/4/98 Laurel, Maryland 21. Monatorie of Funeral Service Comme 22. Name and Address of Fecility
Lemmon Funeral Home Bryan W. Clary 21093 10 W. Padonia Road, Timonium, MD Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, or hear failure. List only ordicause on each line. Approximate Interval Between Onset and Death **Physician** END STAGE CHRONIC OBSTRUCTIVE PULMONARY Immediate Cause (Final disease or condition resulting in death) /Medical e DISEASE YEARS Examiner Due to (or as a consequenca of): Examiner PULMONARY RESTRICTIVE DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of): SEVERE OSTEOPOROSIS WITH YEARS 6876 Physician/Medical Due to (or as a consequence of) THORACIC COMPRESSION FRACTURES & # usa KYPOSCOLIOSIS YEARS 23b. Did tobacco use contributa to the causa of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 21 No 3 ☐ Probably 4 ☐ Unknown CELIAC DISEASE Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed HYPORVENTILATION DUE TO OBESITY paga 2 has 1 Yes 2 No 1 Yes 2 No cartificata 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 ☐ Yes 2 No funaral 28a. Dete of Injury (Month, Day Year) 27 Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1X Natural daath. 1 Yes 2 No 2 Accident after daati 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 6 Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and pleca, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and placa, and due to the cause(s) and manner stated. 29e. Certifier Medical complataly (Check only within 2 To the 29b. Signature and title of sentition 29c. License number 29d. Date signed (Month, Dey, Year) D 25886 30. Neme end eddress of person who completed cause of deeth (11 23e) (Type, Print) LILIA CEBALLOS, M.D., 7505 OSLER DR., TOWSON, MARYLAND 21204 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature State

wha Datidson-Randelle

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 8 06524 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** PIERCE IRVIN FEB. 26 1998 5:30 PM /Medical 4c. County of Death 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 7200 VALLEY COUNTRY CT., APT. 1-A BALTIMORE N/A 8. Dete of Birth (Month, Dey, Yeer) JULY 4, 1905 7. Age (In yrs. last birthdey) If Under 1 Yeer | If Under 24 Hrs. 6 Sex 9. Birthplece (State or Foreign **Funeral** 1₩ 2□ F Months Deys Hours 92 212-05-7099 MARYLAND Director Usuel Residence of Decedent the Maryland 10e State 10b. Count 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show solical Examiner inust be notified at 1 □Xes 2 □ No Director MD N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 7200 VALLEY COUNTRY CT., APT. 1-A 21208 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after (Hygiena. 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) marked other than "natur 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER REAL ESTATE permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe eny Injury or other traumatic event, page. 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) PIERCE MORRIS ANNA BLOOM 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) MARTIN MITNICK, ATTY. 201 N. CHARLES ST., SUITE 1212 BALTO., MD 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Burlel 2 ☐ Cremet HEBREW FRIENDSHIP 3/1/98 BALTIMORE, MD 4 □ Donetion 5 □ Ott 21. Signature of F 22 Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 ns thet ceused the deeth. Do not enter the mode of dying, such as cardiac or use on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Gartre Car anome disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be axecuted physician and s the bunal-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or es e consequence of): datached i Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown caner signed t Records, þ 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24a. Was en eutopsy been certificata has t lirector, page 2 s 1 Tyes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical exeminer? director Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After 1 Naturel 5 Pending 1 Yes 2 No death. investigation after death Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide in 24 hours aft the Funeral Di oplataly filled in Hospital **Settifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated.

2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) end menner stated. 29a. Certifier Medical To the To the Comple 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number 30. Name and address of person moleted cause of death (Item 23a) (Type

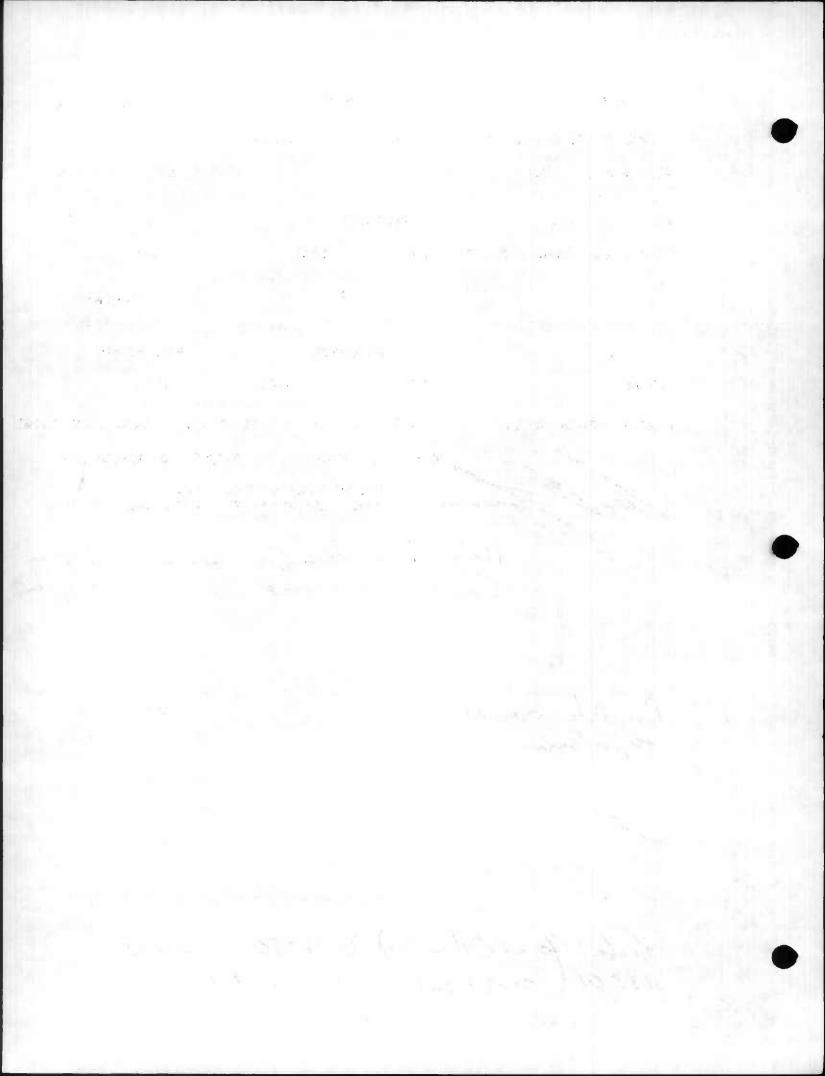
State Registrar

31. Dete filed (Month, Dey, Year)

MAR 0 3 1998

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Kos COVIT 32. Registrer's Signeture whia Davidson



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Catherine A. Price 28,1998 February /Medical 4:42 PM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Franklin Square Hospital Center Baltimore Rosedale If Under 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthdey) **Funeral** Birthplece (State or Foreign Country) Deys 71471910 Months Hours 212-05-2481 1 □ M 2 F 87 Director Baltimore, Md. Usuat Residence of Decedent C ATHERINE JEICE Maryland 21215-0020 10e. Stete 10c. City, Town or Location If is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner mant be notified at 10d. Inside City Limits Baltimore Essex MD Director 1 Yes 2 XNo 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 21221 1116 Tace Drive Apt. 1-C USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 11. Manitet Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural," or item any Injury or other traumatic event, the Medical or other traumatic event Bleck, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Yas, Give White 1 ☐ Yas 2 X No Specify: þ 3 Widowed 4 ☐ Divorced Year or Detes: Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) In own Home Homemaker 7th 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Be Joseph Gramadier Edna Eline 2 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Edna T. Stebbing 1069 S. Marlyn Ave. Baltimore, Md. 21221 Baltimore, 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Locetion - City or Town, Stete 1 ☐ Burial 2 ★ Cremetion 3 ☐ Removel from State Greenmount Crematory3/2/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Joseph N. Zannino Jr. Funeral Hia 263 S. Conkling St. Baltimore, Md. 21224 escor U. anner or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, List only ona cause on each lina. Part1. Enter the disasshock, or haart failuse Approximeta Intervel Between Onset end Deeth **Physician** /Medical Immediata Cause (Finel e Atherosclerotic Cardiovascular Disease 40 Years disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner for Affording Physician: The law requires that the death certificate be executed after death.

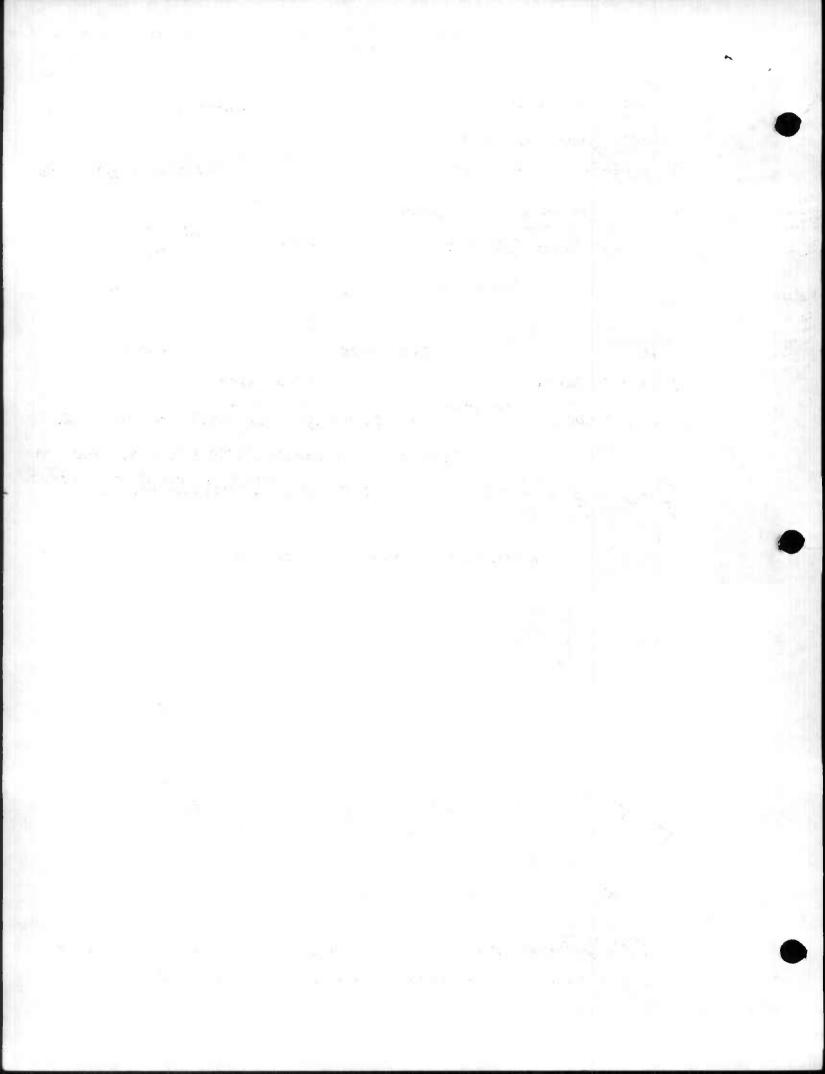
Biractor: After this certificate has been signed by the attending physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760, physician Physician/Medical Due to (or es e consequence of) usa as attending for usa as ata has been signed by the a paga 2 should be detached t Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wara eutopsy findings eveilebte prior to complation of cause of deeth? Completed 24e. Wes an autopsy performed? After this certificata has 1 ☐ Yes 2 ☐ No Be 25. Was case raferrad to medical 26. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2D No P 1 Inpatient 2 ER/Outpetient 3□ DOA To the Hospital or Attending Phy within 24 hours aftar death. To the Funeral Director: After this compiataly filled in by the funeral i 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To tha best of my knowledge, death occurred at the time, data and placa, and due to the causa(s) and menner as stated. Medicai 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred et the time, data and place, and due to the causa(s) end mennar stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) (tenmelor M) February 28, 1998 D25363 30. Nema and addrass of person who complated cause of death (Itam 23a) (Type, Print) 3 Mark Himmelheber MD. 9000 Franklin Square Dr. Balto, Md. 21237 31. Data filad (Month, Day, Yeer)

DHMH 16 Rev 6/95

State

Registrar

03



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth FEBRUARY 27 98 9:00 Am 4e. Fecility Neme (If not institution, give street and number 4b. City, Town, or Location of Deeth 4c. County of Deeth Ba N. Keswick If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 6. Sex 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country) Deys Months 1□M 200F 246-42-0905 Yrs. 0 -16-1926 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Baltimore NA 1 No Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2/2/5 5303 Nelson Auenue U. S.A 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritet Stetus 14. Rece - American Indian, Bieck, White, etc. 1 Never Married 2 Married I □ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☑ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HUSPITAL 12th grade NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) William 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 5303 Avenue ESSIE Petwan Sister Ne Balto, Md 21215 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee F. H. W Walash aden Warre Mid 300 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Sequentielty list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest ultiple 57820 KEJ 000 Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 0 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Was en autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel exeminer? 26. Piece of Deeth (Check only one)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a State

Funeral

Director

"natural", or items 23a or 28a-f show

Peges 1 and 2 should be filed within 72 hours efter inent of Heelih and Mentel hygiene.
ant: If item 27 is marked other than "natural", or item into or other traumatic event, the Medical Eventine ury or other traumatic event, the Medical Eventine.

permit. Pege Department of Important: If any Injury or

should be model thygiene.

Is marked other than "natural"

21215-0020

Baltimore, Maryland

Director

Completed by Funeral

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Physician/Medical Examiner Completed by Be 2

certificate this Affer death.

Attending Physician: after death of prector: / d in by the f To the Hospital o within 24 hours at To the Funeral D completely lilled in

> State Registrar

Certification: Medical

29e. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature again

1 Yes 2 No

27. Menner of Deeth

1 Naturel

2 Accident

3 Suicide

4 Homicide

of certifier

5 Pending investigation

6 Could not be determined

ical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

28e. Dete of Injury (Month, Dey Year)

Mus (Item 23e) (Type, Print)

1 ☐ Inpatienf 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

1 Yes 2 No

28c. Injury et Work?

29d. Dete signed (Month, Day, Year)

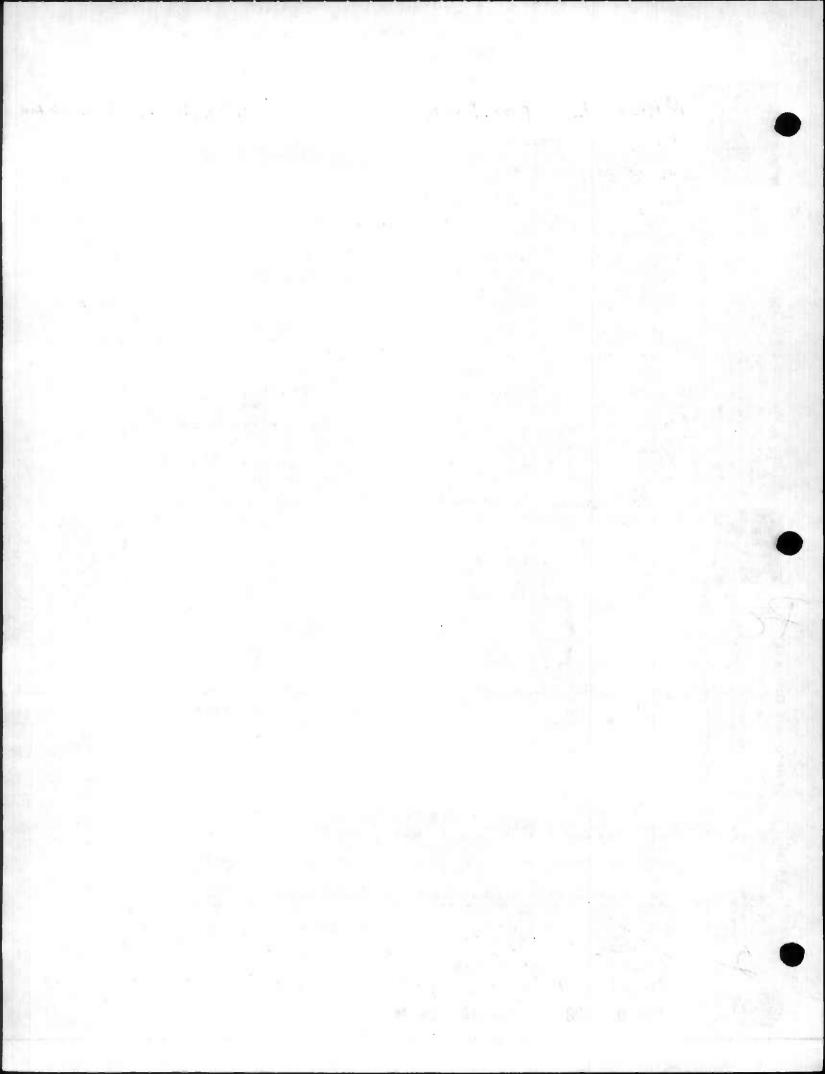
40th STROST Baltinor 21211

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how Injury occurred

2 e Registrar's Signeture 31. Date filed (N th, Day, Year) MAR 0 3 1998

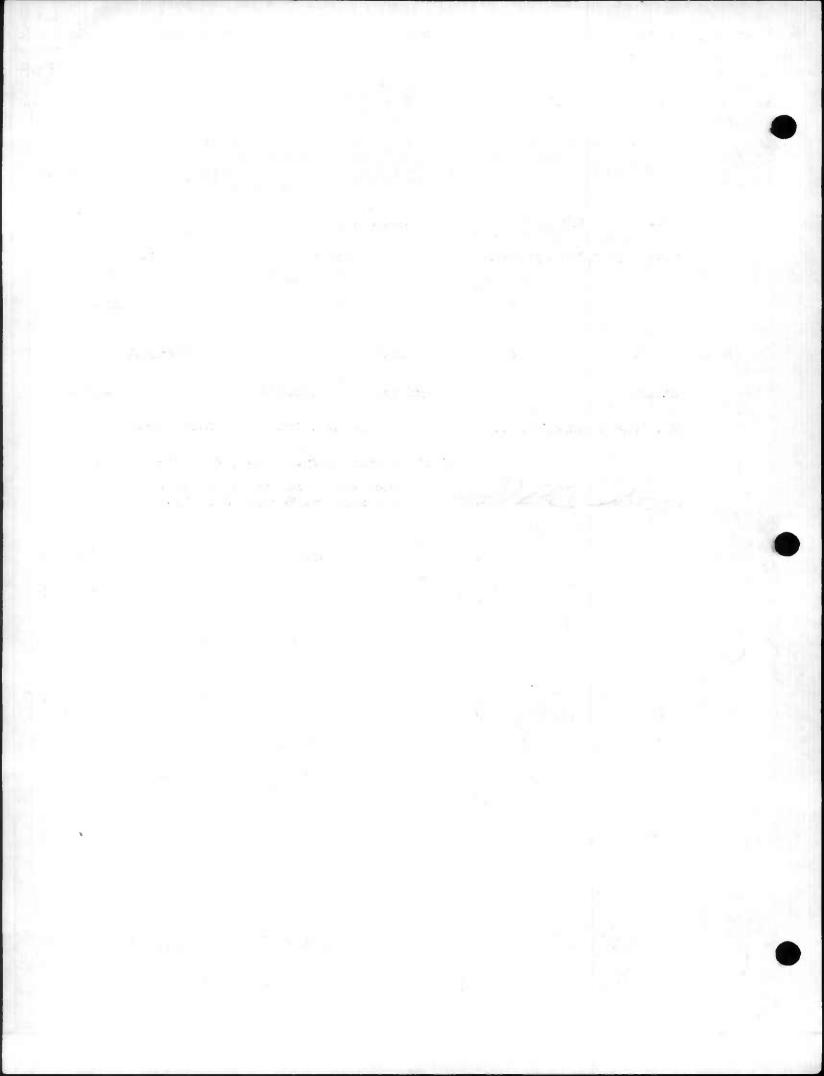


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth PEASE **Physician** Month 50p SEATRICE /Medical 4e. Fecility Neme [If not institution, give street end number] 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore MD Samaritan HOSPITAL 600d Baltimore Cit Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday)

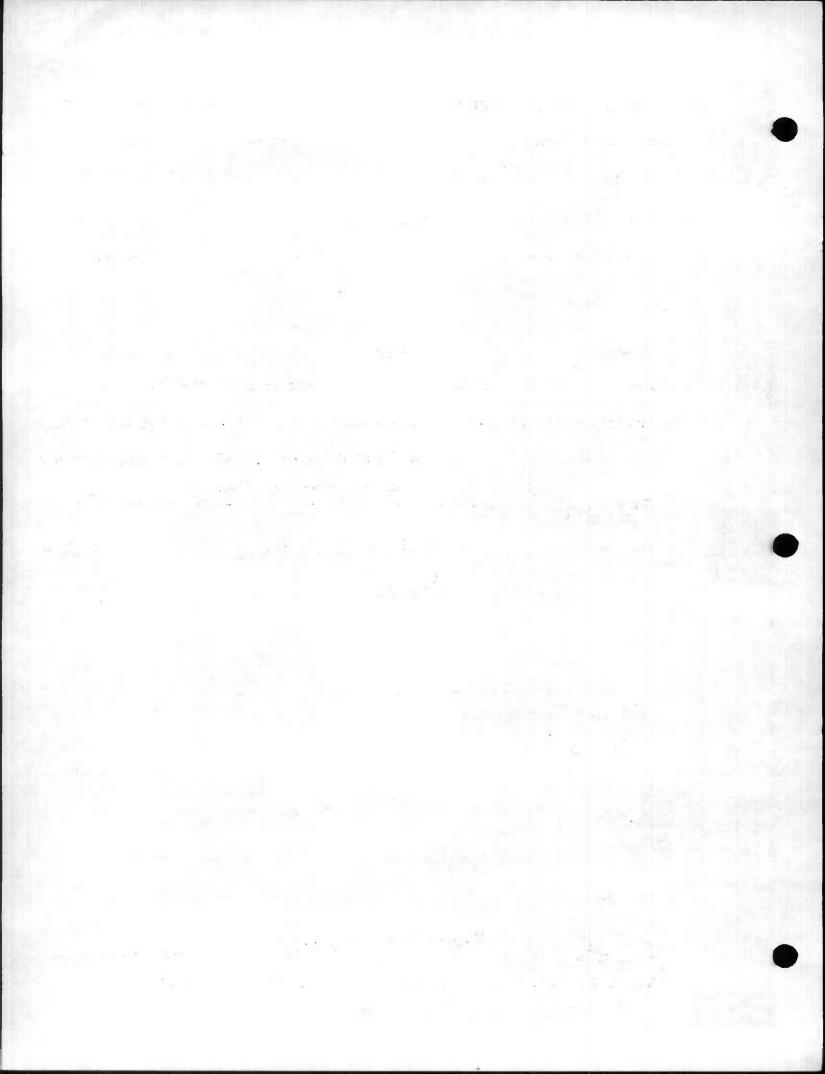
Yrs. Birthpiece (State or Foreign Country) **Funeral** Deys Hours 216289479 1 M 2 F Italy Director Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 PYes 2□No Director Md. N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 items 23a 1601 East Belvedere Ave. 21239 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. filed within 72 hours efter (Hygiene. ther then "netural", or fter 1 Yes 2 X No If Yes, Give Yeer or Detes: 1 Never Merrled 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filled with Depertment of Health end Mentel Hygiene Important: If Item 27 is marked other that any liqury or other traumetic event, trained. Secretary Clerical 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Fernanda Sansone 19e. fnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 332 Landis Ave. Bridgeton, N.J. 08302 Mrs. Olga Cassidy/friend 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Service Corp. Towson, Md. 3/2/98 21. Signature of Europeai Service Licensee 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate fntervel Betw Onset end Death Physician /Medicai Immediete Ceuse (Finel Bilatera Duevmonia diseese or condition resulting in deeth) **Examiner** Physician/Medical Examiner peralin Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): for use P.O. 1 Pert ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Onknown Records, þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? VIMONATY ate hes ronic 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 44 hours efter death. Be 25. Wes cese referred to medicel examiner? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) funeral 27. Menner of Deeth Certification: 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred After 1 Neturei 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medicel Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) end menner steted. edical 29e. Certifier the th 29b. Signature and the of certifier 29c, License number 29d. Date signed (Month, Day, Year) H43420 2/28 30. Name engladdress of person who completed cause of death (Item 23e) (Type, Print) SNIADACH Good Samaritan Hospita JOSEPH D.O. 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

								Death			Reg. No.		
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/Medical Examiner	4e F	Facility Name (If not institution	n, give street en	nd number)				4b. City, To	wn, or Lo	cation of Deeth		nty of Deetl	
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uneral		oclei Security Number	6. Sex	7. Age (In yi	s. lest birthdey	If Under		If Under	24 Hrs.			9. Birtl	hplace (Stete or For
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De o		Richard		Brooks				Marg	garet	: Ke	ennedy		
is mari	19e	. Informent's Neme/Reletions	hip (Type, Print	")	19b. Mail	ing Address	(Street	and Number	er or Run	al Route Numbe	er, City or Tov	vn, Stete, Z	Zip Code)
	A	. Virginia Ph	elan (da	aughter)	352 1	Roseba	nk	Avenu	e B	altimor	e. Mar	vland	1 21212
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State of Maryland / Department of Health and Mental Hygiene

06529 Certificate of Death 2. Data of Death 3. Time of Death Day Month

19-

98

29d. Data signed (Month, Day, Year)

2/20/98

Georgia for Silver Spring 40 20902

5:36 PM

Physician	
/Medical	
Examiner	

1. Decedant's Nama (First, Middla, Last)

Jean Withers Poland

Funeral Director

the Marylend 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at deeth with

permit. Peges 1 and 2 should be filed within 72 hours effer t Depertment of Heelth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or ther any Injury or other treumatic event, the Mental Exerci-

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and s the burial-transit Division of Vital Records, P.O. Box 68760. 98 atten signed by t After this unlerei Attending death. I or Attend after death Director:

4e. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring N If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) Montgomery

9. Birthplace (Stete or Foraign
Country) If Under 1 Yaer 5. Social Security Number 7. Age (In vrs. last birthday) Months 1□M 2\ F Days 579-20-8283 84 1/26/14 VA Usual Rasidance of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits MD 1 ☐ Yes 2 No Montgomery 01ney Director 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 18400 Fairweather Dr. 20832 USA Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yas, Giva Yaar or Datas: 11 Maritel Status Was Decedent of Hispenic Origin? (Spacify Yas or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14 Race - American Indian Bleck, Whita, atc. 1 Navar Married 2 Marriad 1 ☐ Yas 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) Registered Nurse Medical 12 17. Father's Nama (First, Middle, Last) 18. Mothar's Nema (First, Middla, Maidan Surnama) Be Caskie Withers Rosa Bruce Anderson 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 18400 Fairweather Dr., Olney, MD 20832 Nancy Galvin 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stete 1 Burial 2 Caramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chestput Grove Cemetery 2/24/98 Herndon, VA 21. Signatura of Eunaral Sarvige Licensee 22. Name and Address of Facility 721 Elden St., Herndon, VA 20170 emons that ceused the death. Do not antar tha mode of dylng, such as cerdiac or respiratory arrest, no cause on each line. Approximate Interval Between Onset end Death Immediata Cause (Final A Crife My o Aduse INFArctions
Dua to (or as e consaquence of): disease or condition resulting in death) Examiner Heart OseAse Athers clerke to years Sequentially list conditions, if any, leading to immadiata ceusa. Enter Underlying Causa (Diseasa or Injury that Initiated avants rasulting in death) Lest Dua to (or as a consequence of): Physician/Medical Dua to (or es e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to complation of cause of death? 24e. Wes an autopsy parformed? Completed 2200 1 ☐ Yas 2 ☐ No 25. Wes cesa rafarrad to medicel axaminer? Be 26. Place of Deeth (Check only ona) Hospital: 1 inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 10 28a. Dete of Injury (Month, Day Yaar) 28c. Injury at Work? 27. Menner of Deeth 28b. Tima of 28d. Describe how injury occurred Certification: 1 Netural 5 Panding Invastigation 1 Tyas 2 No 2 Accident 6 Could not be 3 Suicida 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 - Homicide

1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated.

10313

29c. Licanse number 109748

State Registrar

à

Medical

29a. Certifier (Check only one)

29b. Signatura and title of certifiar

31. Dete filed (Month, Dey, Year)

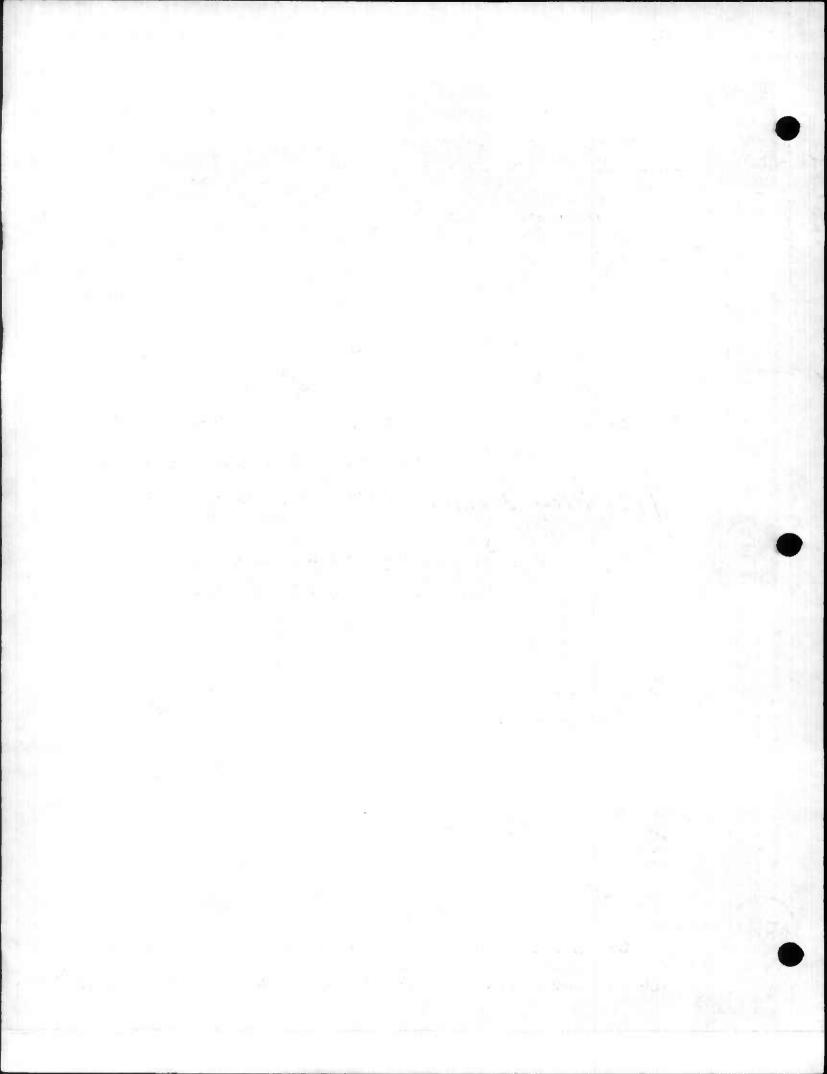
MAR 0 3 1998

Wangfork MD 30. Nama and eddress of person who complated ceuse of deeth (Item 23e) (Type, Print)

32. Registrar's Signeture

Alan R. WEUSTOCK M)

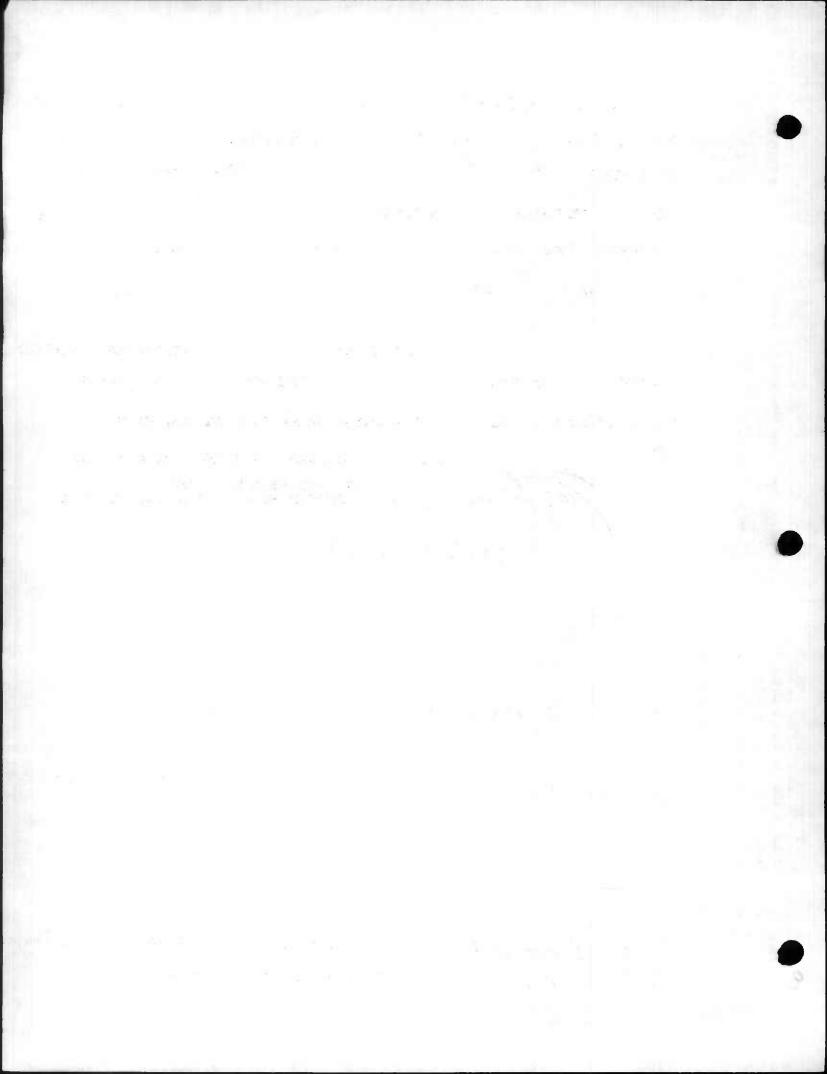
thoras Ties.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death WILLIAM S. REALBERG FEBRUARY 26 1998 1855 HG **Physician** /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HOSPITAL BALTIMORE NORTHWEST BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Yaar Months Dave If Under 24 Hrs. 8. Data of Birth Hours Min. Nanth, Dey, 5. Social Sacurity Number 9. Birthplaca (Stata or Foraign **Funeral** 1**XX** 2□ F Days Director 577-05-8579 Usual Rasidance of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits BALTIMORE BALTIMORE MD 1 Yas 200 No Director 10e Street and Number 10f. Zip Coda t0g. Citizan of What Country? 9 POMONA NORTH, APT. 7 21208 USA death v Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 11 Marital Status filed within 72 hours after 1 Yas XIXNo 1 Navar Married 2 Marriad altimore, Maryland 21215-0020 1 ☐ Yas XX No Specify: Spacity: WHITE 20 3 Widowad 4 Divorcad 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Dacedant's Education (Spacify only highest grada complated) 16b. Kind of Business/Industry al Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) SUPERVISOR LONDONTOWN CORPORATION permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if itam 27 is merked othn any injury or other traumatic event 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Surname) Be RUBIE REALBERG **GERTRUDE** STEINBERG 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) LILLIAN REALBERG / WIFE 9 POMONA NORTH, APT.7; BALTIMORE, MD 21208 20e. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 1 Rurlal 2 Cramation 3 Ramoval from State 4 Donetion 5 Othar (Specify) 2-27-1998 BALTIMORE, MD ARLINGTON-CHIZUK AMUNO 21. Signatura of Funaral Say 22. Nama and Addrass of Facility
SOL LEVINSON & BROS, INC. 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208 complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiratory errest, one cause on each line. Approximata Intervel Batween Onset end Death **Physician** PNEYMONIA /Medical nmediata Cause (F Immediata Cause (F disaasa or condition rasulting in daath) Examiner Dua to (or as a consequance of) Examiner shysician and the bunal-transit Sequantially list conditions, if any, leading to Immediata causa. Entar Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last Due to (or es a consaquance of): Box 68760, physician 99 Physician/Medical Dua to (or as a consequence of): 88 ding P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☑ Unknown DEMENTIA Records, 24b. Were eutopsy findings eveilable prior to complation of cause of deeth? Completed 24a. Was an autopsy performad? certificate has 1 ☐ Yas 2 DoNo 1 Yes 2 Tho Division of Vital Hospital or Attending Physician: 24 hours later death. Funeral Director: After this certifica 25. Was cesa raferred to medical axaminar? Be 26. Pleca of Daath (Chack only one) Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Hospitel: 1 Depatiant 2 ER/Outpatient 3 DOA 2 1 Yas 2 No 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Medical Certification: 5 Pending invastigation 1 Watural 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 4 T Homicida 1 Certifying Phyaician: To the best of my knowledga, deeth occurred et the tima, data and place, and due to the ceusa(s) and mannar as steted.

Medical Examiner: On tha basis of examination and/or invastigation, in my opinion, death occurred et tha tima, data and place, end due to the ceusa(s) and mannar stated. 29a, Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Data signad (Month, Day, Yaar) FEBRY ARY 21. 29b. Signatura and titla of certifier 29c. Llcansa numbar 17773 26 1998 30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print) BALTO MD21133 RAVIMD, NHC 31. Data filed (Month, Day, Yeer) 32. Registrar's Signatura State Julia Davidson Randalle

Registrar



Item: 5 Per Anatomy Board 3-4-98RC Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Daeth C. County of Death **Physician** Alice Elizabeth Redmond /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) Examiner St. Elizabeth's Nursing Center Baltimore County Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-26-1482 212-26-1482 Usual Residence of Decedent Days 1 M 2 TF Yrs. 70 Director Oct. 12, 1929 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3320 Benson Averue 21227 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status unknown Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White λq 3 Widowed 4 Divorced Yeer or Dates: "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mantal Hygiena. marked other than Etementary/Secondary (0-12) College (1-4or 5+) Programer Analyst 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Depertment of Health and Mantal Hy Important: if Nem 27 is marked oth any Injury or other treumatic even page. John Thomas Redmond Miriam Francis Schoolden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Barrett/son 927 Jessica's Lane, Bel Air, Maryland 21014 20b. Piece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility State Anatomy Board, 655 W. Baltimore Street Joseph B, Van Sant Baltimore, Maryland 21201

23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final tars disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner 11/019 EULT Q 1071 attending physician and for use es the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated excellents) certificate be axecu P.O. Box 68760 Physician/Medical that initiated events resulting in death) Lest as e consequence of) 23b. Did tobacco dsa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the detached 1 Nos 2 No 3 Probably 4 Unknown Š signed Division of Vital Records, p ed bluods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen has 1 Yes 2 No 1 ☐ Yes 2 ☐ No b Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etaly filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 Yes 2 June 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Madicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Funer completaly fil Medical 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 5626 30. Name and address of Aurson who completed ca use of death (ttem 23a) (Type, Print) CN 31. Date filed (Month, Day, Year) 32. Registral's B State MAR 0 8 1998 Registrar **DHMH 16 Rsv 6/95**

Comond

Item: 19b Per Anatomy Board Film G-757 3-4-98Rc Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Name (First, Middla, Last) 2. Data of Deeth February **Physician** /Medical Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death Examiner HO Baltimore City If Undar 1 Yaar If Undar 24 Data of Birth (Month, Day, Yact. 16, Sociei Security Number 7. Aga (In yrs. last birthday) Birthpiace (State or Foraign Country) **Funeral** Months Deys 15 M 2□ F 80 Yrs. 1919 Director Oct. Maryland 178-01-4286 Usual Residence of Dacadant 10a Stata 10c. City, Town or Location the Marylan 10b County 10d. Insida City Limits 1 Vas 2 No Director 28a-f Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Herns 23a or : 1111 Park Avenue 21201 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No If Yas, Giva Yeer or Datas: 1941-46 Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Maritai Status Race - Amarican Indian, Black, Whita, etc. the Medical Examiner 72 hours after 1 ☐ Nevar Married 2 ☐ Married 21215-0020 8 1 ☐ Yas 2 ☑ No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education 16a. Decadant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) (Spacify only highest grade completed) Elamantary/Secondary (0-12) Coilega (1-4or 5+) Hygiene. Self Employed 12 Accountant Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Pages 1 and 2 should be nent of Health and Mental Fannie Carliner Louis Rosen 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) # nt of Health a :: If Itsem 27 is r or other tra 1503 13202 Bluhill Road, Wheaton, Maryland 20906 Julie Rosen/daughter 20b. Piace of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Crametion 3 ☐ Ramovai from Stata Department of Important: If any injury or 4 Donation 5 Othar (Spacify) 21. Signatura of Funaral Sarvice Licensee Joseph B. Van State Anatomy Board, 655 W. Baltimore Street Santa Baltimore, Maryland 21201 23a. Part1 Entar tha disaesa, or complications that caused the daath. Do not antar tha mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. Approximata Intervel Batwaan Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in daath) Examiner Examiner penia The law requires that the deeth certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated evants rasulting in death) Last Dua to (er as a consequence of): Box 68760. Physician/Medicai the Dua to (or as e consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 8 24b. Wara autopsy findings eveileble prior to compiation of causa of daath? page 2 should Completed 24e. Was an autopsy 1 Yas 2 No 1 Yes 20 No this certificata Division of Vital or Attending Physician: director. Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA the funaral Data of Injury (Month, Day Year) 27. Manney of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No death. 2 Accidant 24 hours after deat Funeral Director: 6 Could not be datarminad 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rurel Routa Number, City or Town, Stata) fillad in by 4 Homicida Hospital 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

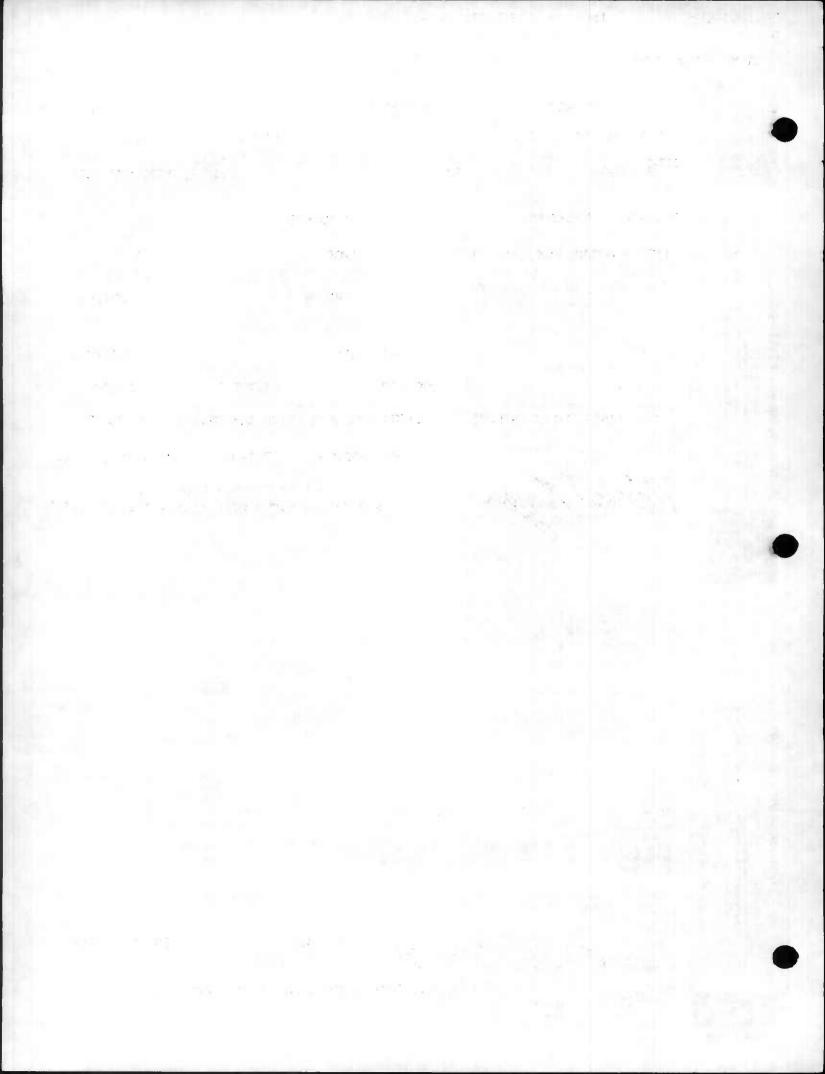
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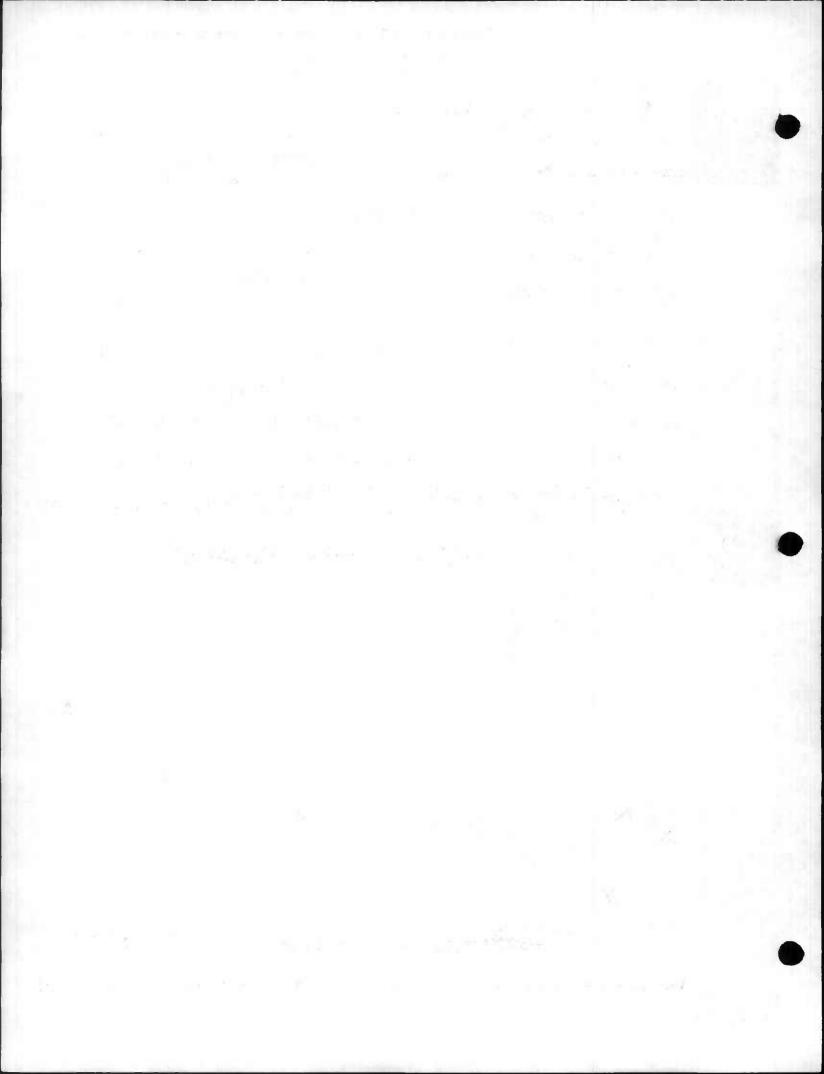
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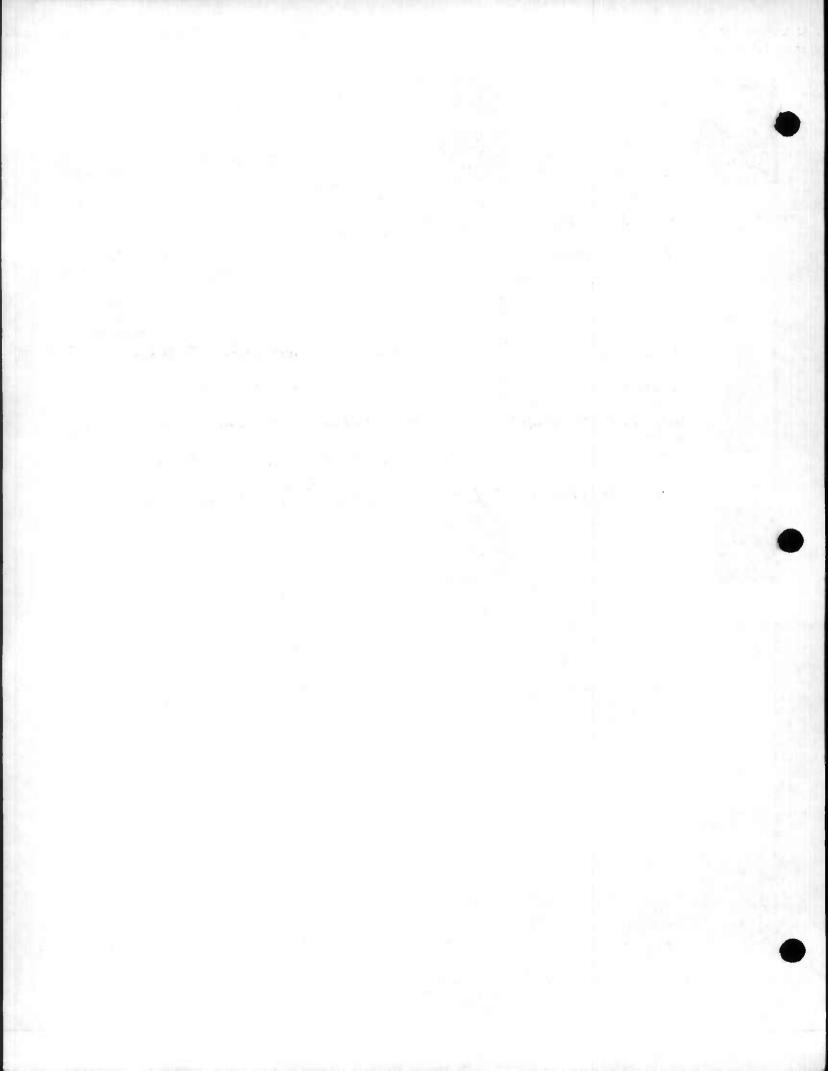
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Registrar



1. Decedent's Name (First, Middla, Last)

Month **Physician** DEBRA A. REICH 11:48 pm 1998 February 28 /Medical 4e. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Harford 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) June 29, 1 If Under 1 Year If Undar 24 Hrs. 9. Birthplece (Stete or Foreign Country) Maryland 7. Aga (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Deys Hours 215-56-1701 Yrs. Director 1950 Usuel Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Insida City Limits Pages 1 end 2 should be filed within 72 hours after death with the Marylar next of Health and Mental Hygiene.
Int if Item 27 is marked other then "natural", or Items 23a or 28a-f show ary or other traumatic event, it a Modical Examines must be notified at Maryland Harford Bel Air 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1905 Leeland Court 21015 U.S.A. Completed by Funeral 12. Was Decedant Evar in U,S Armed Forces? Wes Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) Race - American Indien, Bieck, Whita, atc. 11. Maritel Status 1 ☐ Yes 2 X No If Yes, Giva Yaar or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th grade Cosmotology Beautician 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Joel J. Bednego Mildred C. Coard 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Paul K. Reich (Husband) 1905 Leeland Court. Bel Air. MD. 21015 20e. Method of Disposition 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Bel Air Mem. Gardens 4 ☐ Donation 5 🖾 Other (Specify) 3/4/98 Bel Air, Maryland 22. Name and Address of Fecility
Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21 21. Signature of uneral Service Licenses ~ 21014 and Inter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. Ust only one cause on each line. Physician LIVER /Medical Immediate Cause (Final disease or condition resulting in death) ADENOCARCINOMA Examiner Examiner t or Attending Physician: The law requires that the death certificate be executed the death.

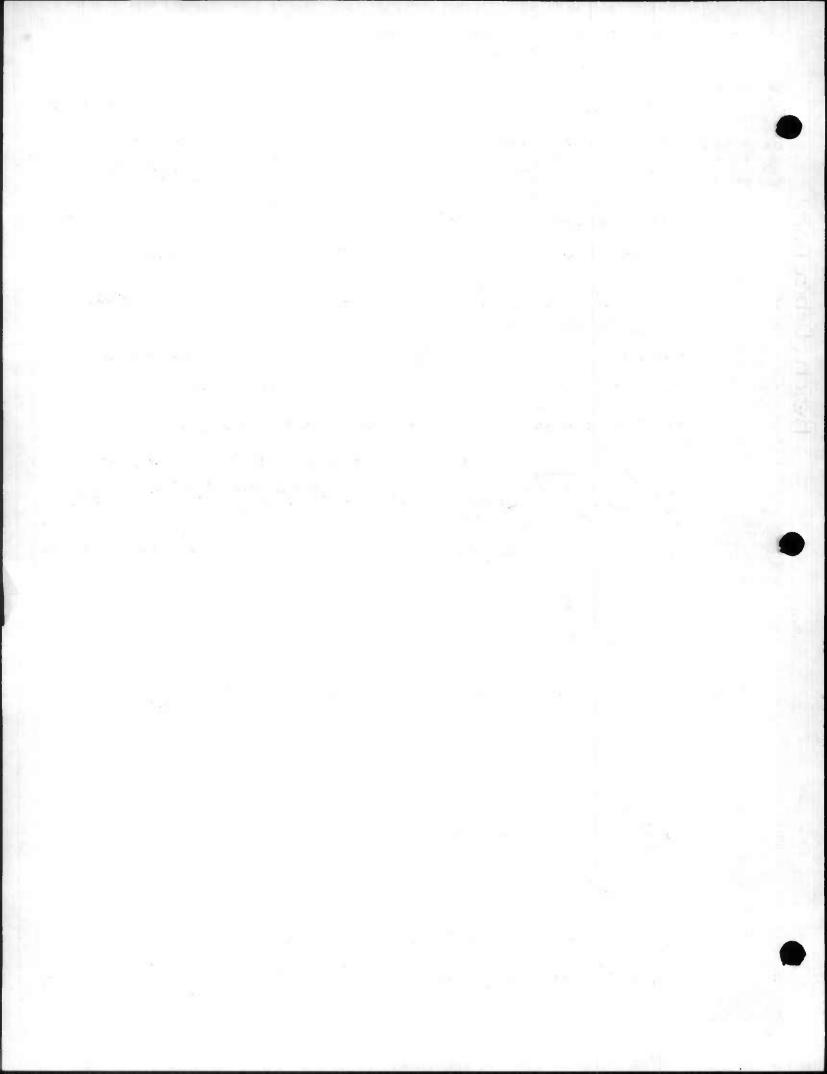
Director: After this certificate has been signed by the attending physician and in by the innertal director, page 2 should be deteched for use as the burial-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Undarlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 212 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 Yes 2 No 1 🗷 Inpatient Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify) edical Certification: To 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manney of Deeth 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyeicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29e. Certifier (Check only one) 29b. Signeture end titla di certifi 29c. License number 29d. Data signed (Month, Day, Year) March 2. 1998 me and address of person who completed cause of death (Item 23a) (Type, Print) 2112 32 Registral's Stonatura (1998) 31. Dete filed (Month, Dev. Year) MAR 0 3 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Dete of Deeth

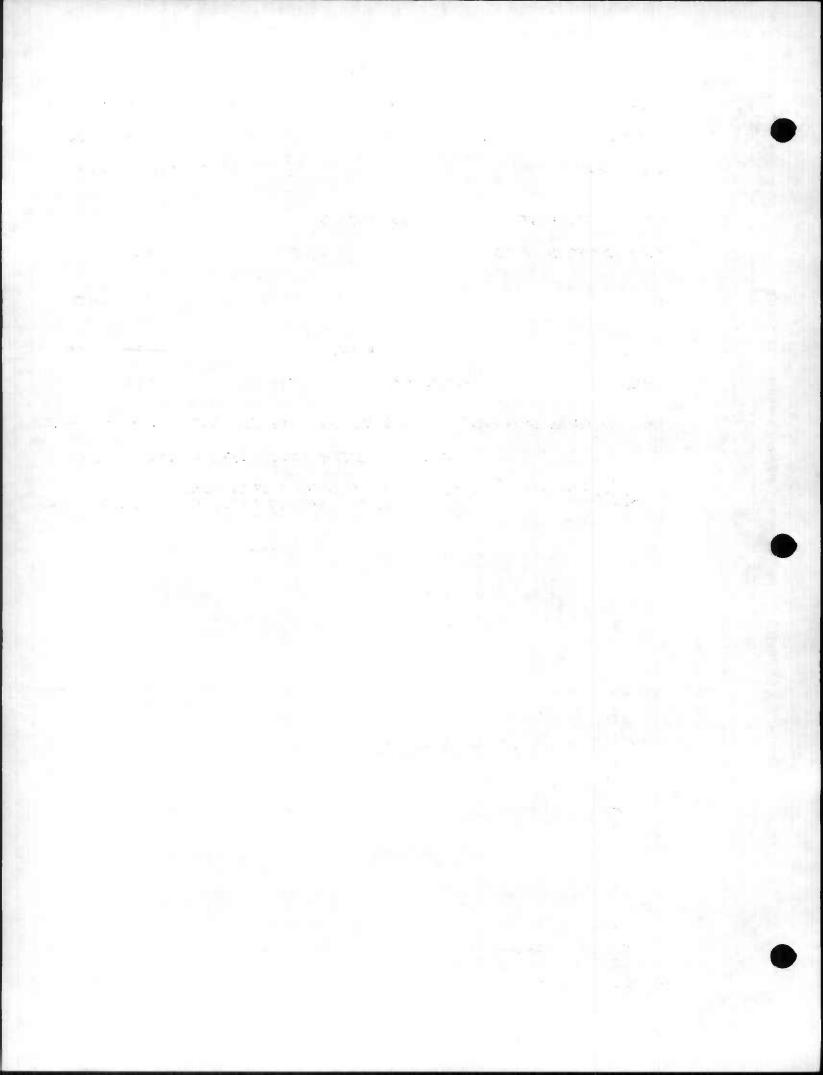
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State Registrar



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb. **Physician** 9:00am Rowlett S. Jerome * /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore 1729 Rutland Avenue If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Yrs 212-50-3955 Director 49 Md 11 - 03 - 48Usual Residence of Dacedent the Marylend 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or flems 23s or 28s-f show traumstic avent, the Medical Examiner must be notified at XIX Yes 2 No Md NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1729 Rutland Avenue 21213 USA Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 12 should be filled within 72 hours efter on and Mentel Hygiene. Is marked other than "natural", or its 1 ☐ Yes 2 ☐ No If Yas, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Aq 3€Vidowed 4 Divorcad Black Year or Dates Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Work Elementary/Secondary (0-12) College (1-4or 5+) Laborer Bureau of Water 8th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Be Randolph Rowlett Josephine Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 21213 mit. Pages 1 end 2 partment of Health e portant: If item 27 Ir y Injury or other tra Josephine Rowlett 1729 Rutland Avenue Baltimore, Maryland 20b. Placa of Disposition (Nama of cemetery, crematory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 R nover wom State permit. Page Department of Important: If any Injury or Voshell Mem. Gardens 03-04+98 Dundalk, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21 Sign of Funaral Sarvice License Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final a. Non-small cell carcinoma of the Lung,
Dua to (or as a consequence of): Lycars disease or condition resulting in death) Examiner metastatic to brain bone Examiner sician end burial-transit certificate be executed Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury physician s the burial Box 68760 Physician/Medicai that initiated events resulting in death) Last Due to (or as a consequence of) 80 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. the detached signed by t 1 Yes 2 No 3 XProbably 4 Unknown Records, þ 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peed hes 1 Yas 20 No 1 Yes 2 No certificate Division of Vital Hospital at Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1□ Yes 2□ No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of After 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 - Homicide afte To the Rospita within 24 Hours Completely file 29a. Cartifiai 🗺 Certifying Physicien: To the best of my knowledga, death occurrad at the time, date and place, and dua to tha causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. 30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

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Davidson

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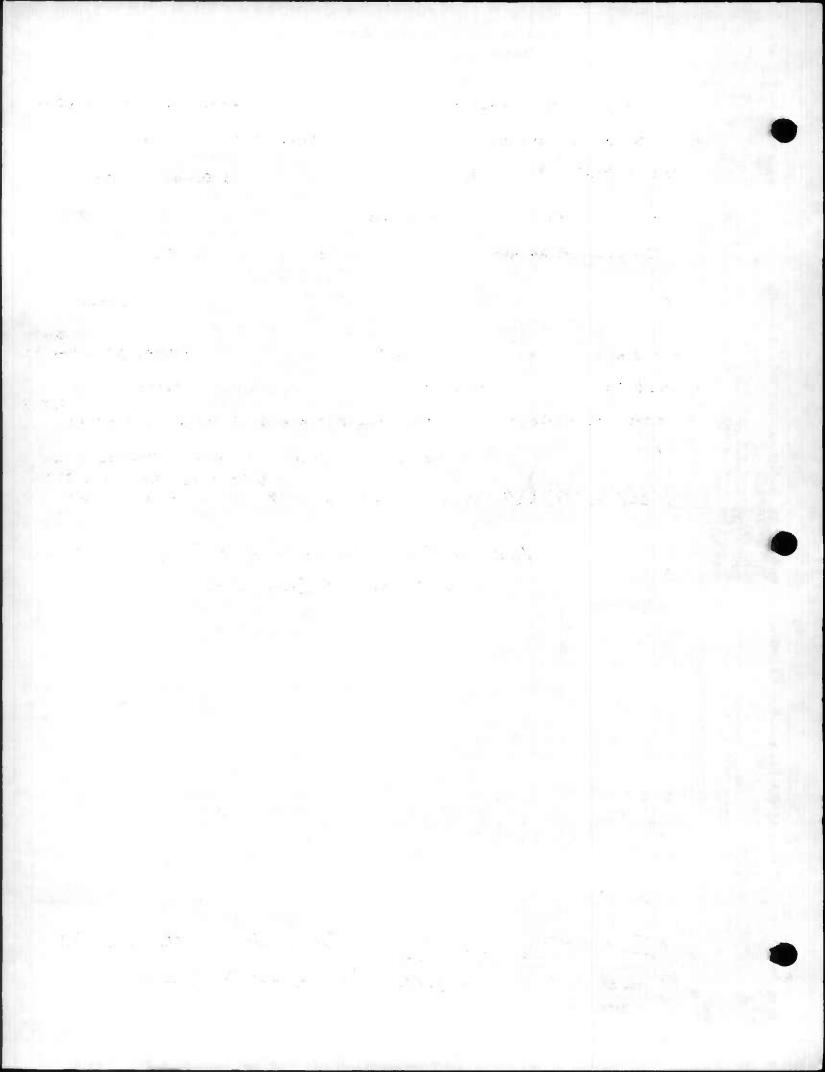
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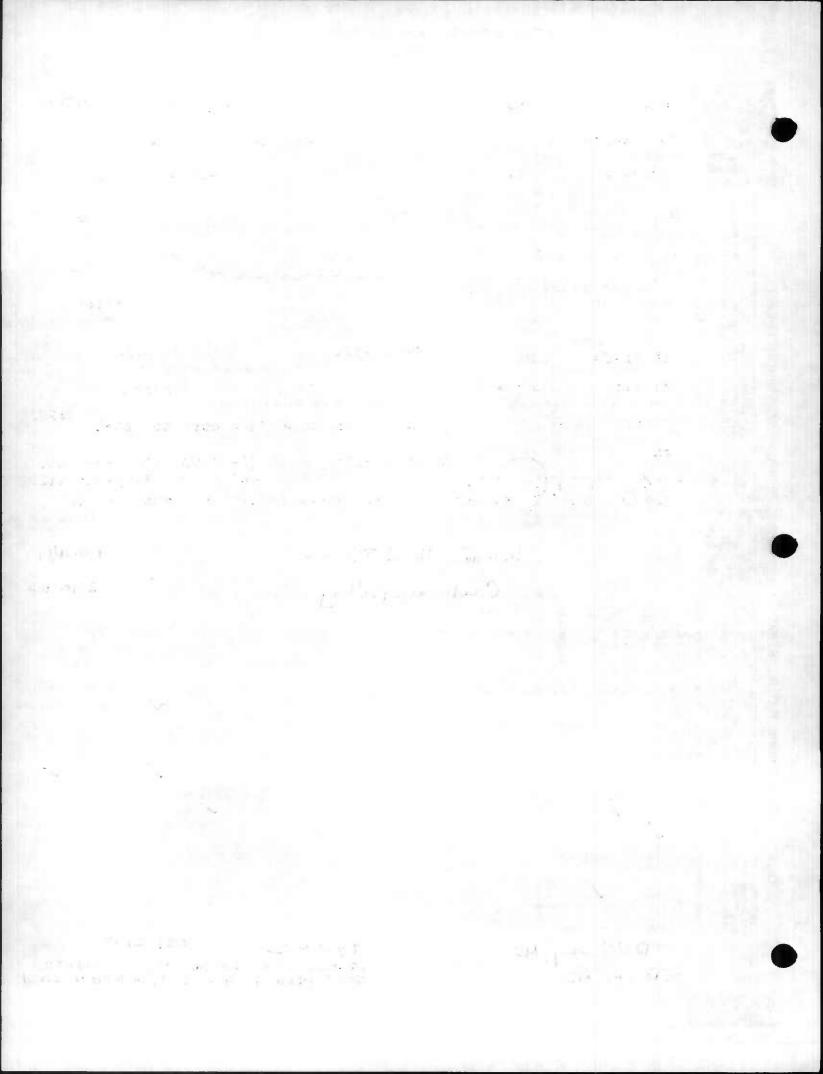
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 6:00pm Mary Ranson Feb. 28, 98 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 2600 Saffa Road Baltimore Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. If Under 1 Year 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 F 212-26-2957 90 Director VA Usual Residence of Decedent the Meryland 10c. City Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at Md. X1 Yas 2 No NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2600 Saffa Road 21222 Funeral USA 12. Was Decedant Ever in U.S. Armed Forcas? 1 ☐ Yes Z V No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 end 2 should be fited within 72 hours efter. Department of Health and Mental Hygiene. If them 27 is merked other than "natural", or iter any Injury or other traumatic event 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yas 2 No Specify p 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Housewife in home 7th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) William Carter Ella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 Turner 2600 Saffa Road Baltimore, Maryland of Disposition (Name of Date 20c. Location-City or Tow Ranson Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Dulaney Valley Cem. 03-04-98 Timonium, Md. 21 Signatura of Funeral Service Lice 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue MO 23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Ischemic Heart 1 mouth Examiner Examiner 2 years audiomyopat physicien and the buriel-trensit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 98 980 0 23b. Did tobacco use contributs to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. deteched the 1 Yes 20 No 3 Probably 4 Unknown signed by Division of Vital Records, à 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 1 Yes 2 No 2 No 25. Was cese referred to medical exeminer? Be 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manger of Deeth 28a. Dete of Injury (Month, Day Year) funerel 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident ofter death 6 Could not be determined 28f. Location (Streat and Number or Rural Route Number, City or Town, Stele) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ A 24 hou. Funeral P 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. Licensa number 29d. Date signad (Month, Day, Year) 29b. Signature and title of certifier 03 02 98 D0052582 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOHNS HOPKINS BAYVIEW LIBORAL CENTER

D. MCKAY, MD

6505 HOPKINS BAYVIEW CIRCLE, BALTIMORE ND 212 5505 HOPKINS BAYVIEW CIBCLE, BALTIMORE HD 21224 31. Date filed (Month, Pay, Year) 32. Registrar's Signature State ulia Davidson 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month RUMNEY 3333 1998 25 FEBRUARY 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death

21211

SINAL HOSPITAL

BALTIMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer)

eb

Birthplece (State or Foreign
Country)

10d. Inside City Limits

Approximete Intervel Between Onset and Death

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

1 Yes 2 No

BALTIMORE, MD 21215

X□XYes 2□No

23,1917 Maryland

10g. Citizen of Whet Country?

USA

Bleck, White, etc.

white

In Own Home

Physician /Medical Examiner

EMILY

HOSPITAL

10b. County

829 W. 38th Street

6. Sex

1 M 250 F

N/A

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

SINAI

Maryland

10e. Street and Number

10e Stete

Director

5. Social Security Number

212-28-3693

Usuel Residence of Decedent

Funeral Director

d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at death filed within 72 hours aftar I Hygiane.

permit. Pagas 1 and 2 should be file Depertment of Health and Mantal Hy Important: if Itam 27 Is marked oth any liqury or other traumatic event 2008. **Physician**

Saltimore, Maryland 21215-0020

/Medical Examiner

requires that the daath certificate be executed nding physician and use as the buriel-tran Box 68760. use as P.O. à Records, The law has certificata of Vital Physician: this funeral Vision or Attending Party after After After

Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Merried Married 1 ☐ Yes 2 ☑ No if Yes, Give 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Be Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Walter M. McFadden H. Cunningham 10 19e. Informent's Neme/Relationship (Type. Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Joseph W. McCartin 10207 Southmoor Dr. Silver Spring, MD 20901 Son 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State Dulaney Valley Mem. 3/2/98 Cockeysville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Burgee-Henss Funeral Home, 3631 Falls road Baltimo 3631 Falls road Baltimore, MD Immediate Ceuse (Final diseese or condition resulting in death) ACUTE PANGREATITIS Physician/Medical Examiner RETENTION RINARY Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of) Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown - INFARCT DEMENTIA à Completed 24e. Wes en eutopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 MInpatient 2 □ ER/Outpetient 3 □ DOA 28a. Date of injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Bowerson AS 2402321-5B-9238 RESIDENT PHYSIGAN FEBRUARY 25, 1998

R. BOWERS, MD 2421 WEST BELVEDERE AVENUE

32. Registrar's Signeture

7. Age (In yrs. last birthday)

8 1 Yrs.

10c. City. Town or Location

Baltimore

10f. Zip Code

State Registrar Jamelle

31. Dete filed (Month, Dey, Year)

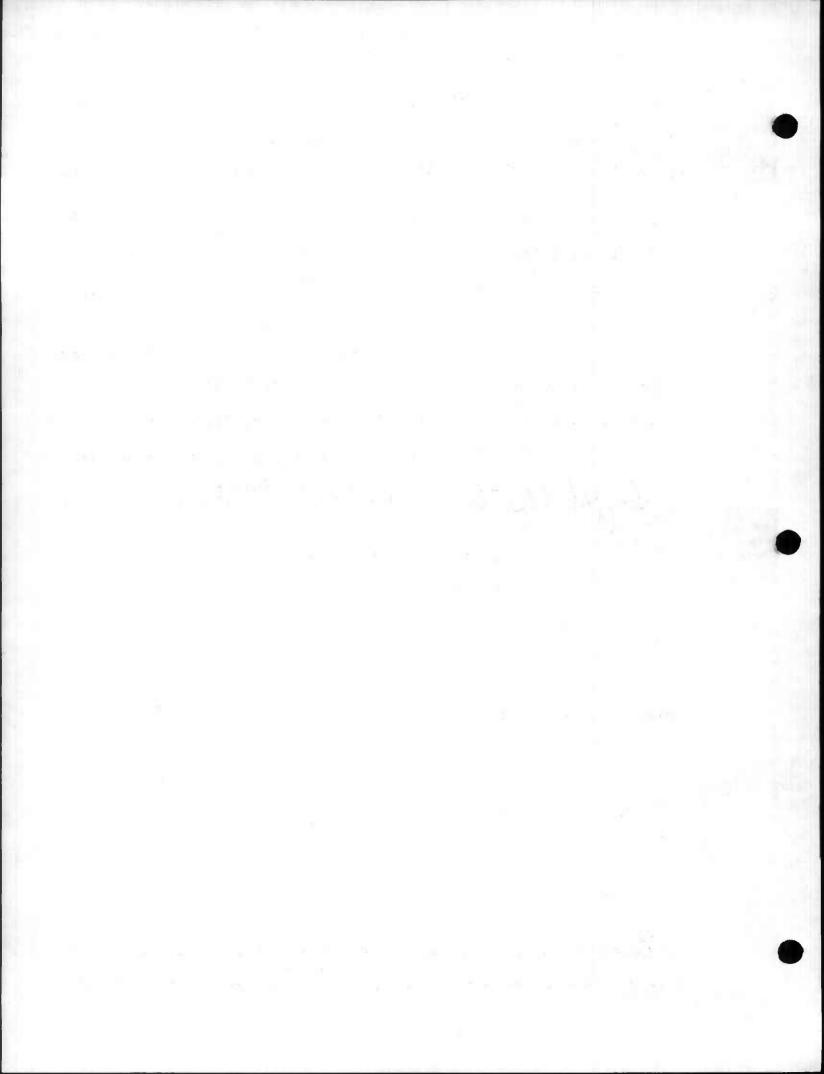
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deem Day 27, 1998 Rebruary 27, 1998 cation of Death 4c. County of Death 2. Dete of Deeth 3. Time of Death 1998 7:32 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore If Under 24 Hrs. Hours Min. B. Date of Bird. (Month, Da MARY I And 5. Social Security Number 40SpitAL GENERAL If Under 1 Year Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 2□ F Months Deys 213-20-8069 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BAKTimore 1 Yes 2 □ No MD 10e. Street and Number 10g. Citizen of Whet Country? 211 21223 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married Yes Give Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) uborev UNK UNK tuclony Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) UNK 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) -Guardian 20b. Placa of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 2-2898 Lansdowne, mD. Albert P. Wylie 7/H 4 □ Donation 5 □ Othar (Specify) 21. Signeture of Funeral Servica Licenses BANTHINE, WD, 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Immediata Cause (Final diseese or condition resulting in death) bua to (or as a consequence of) Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Cause (Disaasa or Injury that initiated evants resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to madical examiner? 26. Place of Death (Check only ona)

Attending Physician: The law requires that the death certificate be executed signed by the attending p

certificete has

this

After

our affer dean

funeral director.

Division of Vital Records, P.O. Box 68760,

Physician /Medical

Examiner

Physician

/Medical

Examiner

by Funeral Director

Completed

Be

Director

permit. Peges 1 and 2 should be filed within 72 hours eftar deeth with the Maryland Department of Health and Mental Hygiena. Important: If Itam 27 ie marked other than "natural", or Itams 23a or 28a-f ehow any injury or other traumatic event.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Completed by Be Medical Certification: To

1 Yes 2 No

27. Manner of Death 5 Panding investigation 6 Could not be

2 Accident 3 Suicide

4 Homicide

29b. Signature and titla of certifies

31. Date filed (Month, Day,

29a. Certifier

1 Inpatient 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Straat and Number or Rural Route Number, City or Town, State)

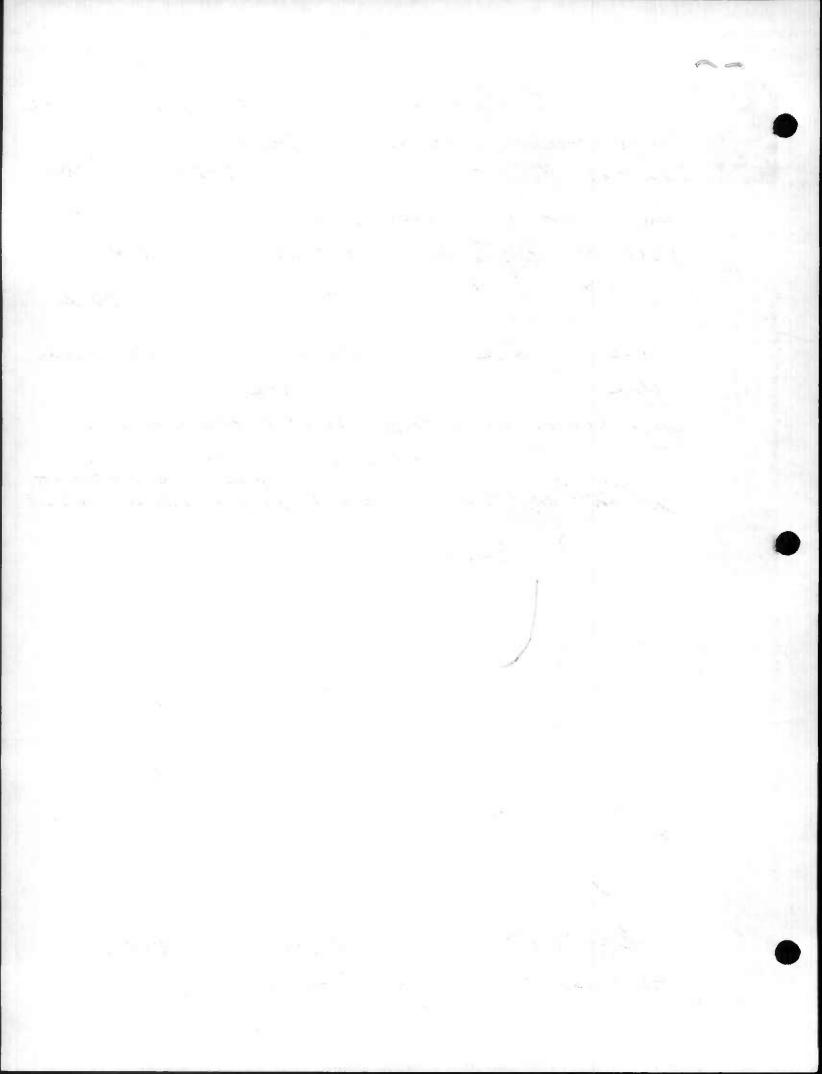
12 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of parson who complated cause of daath (Itam 23a) (Type, Print)

10 32. Registrar's Signature

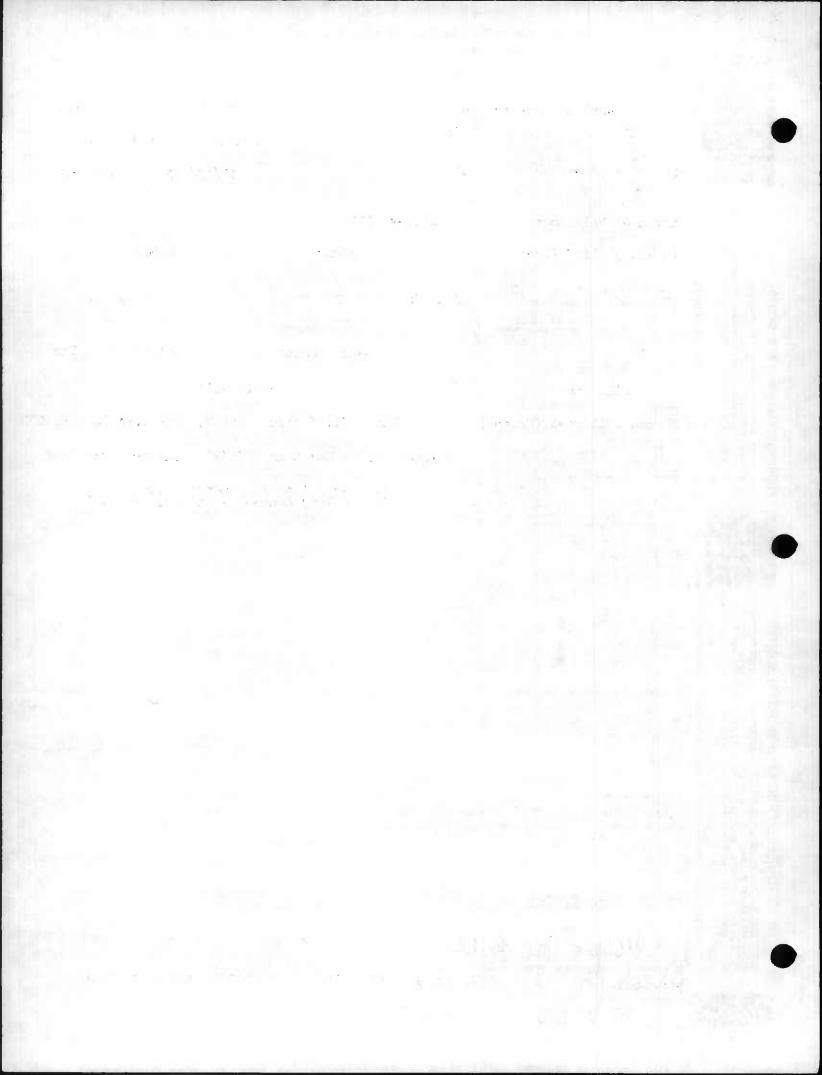
MARYLAND GENERAL HOSPITAL

State Registrar

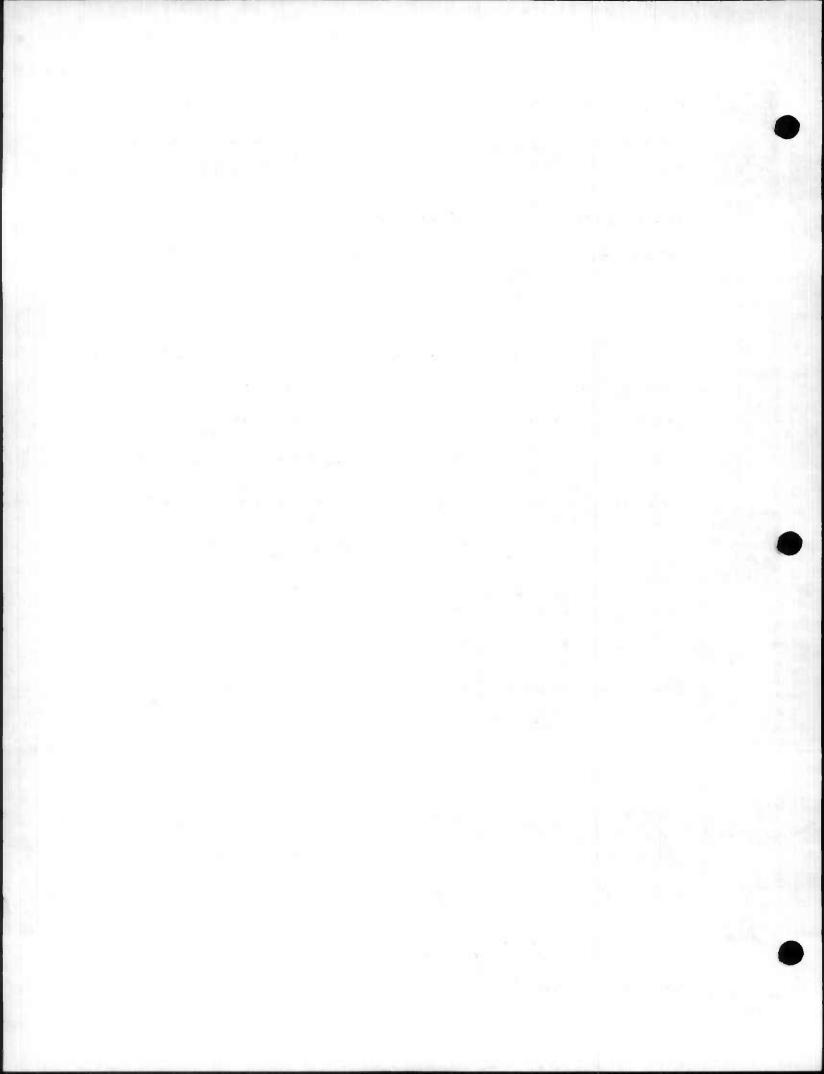


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Physicia				D 1				N	onth ARCH	2, 199	Year		ll AM
/Medica Examine	al er	Charles 4a Facility Name (If not institution, given 13 WINDY CLIFF	Royston va street and numb DIACE Al			4	4b. City, Town, o			4c. County		- X • .1	LI INI
"							COCKEY				IMORI		
Funeral Director			Sax XXM 2□F	Aga (In yrs. 39		If Under 1 Yaar Months Days	If Under 24 H Hours Mi	n. (A	ale of Birth Month, Dey 2/15/	y, Year) Country)			
fand tand	-	10a. State 10b. County									10	d. Inside	City Limits
Mary H sh	i to	Maryland Baltimo	re		Cockeys	ville						1 XY	es 2 No
or 28	ire	10e. Street and Number				10f. Zip Code			1	0g. Citizen of V	Vhal Count	ry?	
23a	raic	13 Windy Cliff P	lace			21030				U.S.A			
urs a	by Fur	11. Marital Status Naver Marriad 2 Married 3 Widowed 4 Divorced	Armed Force	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes, Give Yes, Give Yes or Datas: 4/78-4/82 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, W Specify: W Specify: W Specify: W							k, Whita, e	IC.	
n 72 hours "natural",	pet	15. Decedent's E	ducetion		16a. Deceder	nt's Usual Occup	ation	vorkina		16b. Kind of Bu	siness/Ind	ustry	
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ith a trac		Sharon Childress				ndy Clif							121030
-755	1	20e. Method of Disposition	\/	20b.	Plece of Dispositi	ion (Neme of		De	-	20c. Location -			
y :: #		1 N Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			laney Va			3/6	/98	Timoniu	m, Ma	ryla	and
permit. Par Department Important: any Injury ang Louin		21. Signature of Funeral Service Lice				lame end Addre		1 '					
Depa Impo any I	A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Md 2												
be axecuted ician and burial-transit	Examiner	disease or condition resulting in death) Sequentially list conditions,	b	Due to (AND COCAIN	ence of):					1		
hysicia	Cause (Disease or Injury that initiated events resulting in deethy) Last Dua to (or as a consequence of):												
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that the led by th datachi	by Physician/Me	Tax II. Other arginicant conditions		II DULTIOL TO	onling in the und	enying cause gre	en in rossi.			'es 2∐No			Unkno
law requiras as been sign	Completed b								24a. Wes a perfor	an autopsy mad?	ava	re autops ilable pri inpletion of death?	sy findings or to of ceusa
Physician: The law require this cartificate has been siral director, paga 2 should	E								1 🗖 Y	es 2□No	12	Yes 2	2□ No
ysician: The L s cartificate ha director, paga	Be	25. Was cese referred to medical axaminer?					26. Place of D	eath (Ch	eck only o	ne)			
Physician: this cartific	2	Y Yes 2□ No	Hospital:	atient 2	ER/Outpatient	3LI DOA				ence 6 □Oth		1)	
aling Ph. After th funeral	.i.o	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of (Month,	Dey Yeer)	28b. Time of Injury	A 28c. Injur		28d.	Describe h	ow injury occur	red		
l or Attending after death. Director: After d in by the fune	Certification:	2 ☐ Accident Investigation 3 ☐ Suicida 6 IO Could not t	Tound.3/	2/98	found:2:12	2 ^M 1 1	Yes 2XXNo		nown	treet end Numl	or or Dure	I Doute Al	himbor
or Attendation of the death Director:	T	4 Homicide determined	building		ome, farm, stree fy)	t, factory, offica			City or Tow	n, Stete13 W	indy C	liff F	Place,
Hospi 24 hou Funer taty fill	edical C	29a. Certifier 1 Certifying Proceedings one 2 Addedical Example 1	hysician: To the bearing and manner	st of my kno	wiedge, death o	occurred at the tir stigetion, in my o	me, date and pla opinion, death oc	ice, and c	due to the d	le, Mary eause(s) and ma date end plece,	anner es st	eted. the ceus	se(s)
A A V	-	29b. Signethre and little of certifier	0	Juliou.		29c. Licens	se number			29d. Date signe	d (Month, i	Dey, Year	r)
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To the within 2 To the comple		Mayine (Bel She				.M.E			PARCH	2, 19	90	
To the Within To the compl		30. Name and address of person who	completed ceuse	of death (Ite	m 23a) (Type, Pr	int		timo	re, M				

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ne	er	4e. Fecility Nema (If not i		street end number)					46. City, Town, Baltimon		Deeth	4c. County Baltim			
I		5. Sociel Security Numbe 220–30–1106	er 6. Sex	7. Age	e (In yrs. Ias 7	t birthday) Yrs.	If Under Months		If Under 24		of Birth oth, Day st 20	9. Birthplece (Stette Country) 0,1910 Baltimore, Ma			
	1	Usual Residence of Dace 10a. State 10b.	dant . County		10c. City,	Town or Loc	cation					10d.		Od. inside City Li	
	ctor	Maryland Bal	ltimore		Baltin	nare Co	unty							1□ Yes 2¼	
	ai Directo	10e. Street end Number 1141 Reames Ro	oad				10f. Zip				10	10g. Citizen of Whet Country?			
	by Funeral	11. Maritel Status 1 Never Merried 2 3 Widowed 4 0	2 Married	12. Was Decedent & Armed Forces? 1 ☐ Yes 2 ☒ N If Yas, Give Year or Detes:		If	Vas Deced Yes, spec	cify Cub	dispanic Orlgin en, Mexican, P Specify:	? (Specify Yes uerto Rican, e	or No-		e - America k, White, c	etc.	
traumatic event, the Medical	Completed	15. [(Specify on	Decedent's Education of the Education of	cation completed)		16a. Deced (Give) life. D	ent's Usua kind of wo	rk done	during most of	working	1	6b. Kind of Bu			
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	Be	17. Fether's Neme (First,				18. Mother's Neme (First, Middla, Maldan Surname) Emma Winkler						e)			
	2	Fred G. Magsar 19a. Informant's Name/F		pe, Print)		19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code						Code)			
		Margaret E. Re	eid (Dau	ghter)		1617 R	eid D	rive	Joppa,	Maryland	2108	5			
		20e. Method of Disposition 1 Buriel 2 □ Cre		emoval from State	cerr	e of Dispos letery, crem	etory or o	ther ple		Dete		0c. Location -			
any injury or other	4 Donetion 5 Other (Specify) Gardens of Faith Cem. March 4, 1998 Baltimor										altimore	, Mary	land		
	Lassahn Funeral Home, Inc. Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-													5	
ľ	T	23a. Part1. Enter the dis shock, or haert fallu	sease, or compliance. List only on	cations thet caused a cause on each lin	the death.								30 402	Approximate Interval Batwee	
		Immediete Ceuse (Final diseese or condition resulting in deeth)	а	Congle	twe	HU s e consequ	uance of):	Fa	ilme	,				Onset end Deet	
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	ysici	Pert il. Other significant	conditions con	tributing to death bu	ıt not resulti	ng in the un	darlying c	ause giv	en in Pert I.	231	Did tob	acco use cor	ntribute to	the cause of de	
	by Ph										1 🗆 Ye	2 ☑ No	3 Prob	ably 4□Unk	
	Completed									24a	performed? eveileble		ra autopsy findi ileble prior to appletion of caus- leeth?		
	Co										1 🗆 Yes	2 No	1□	Yes 2□ No	
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	tion: To	27. Menner of Daeth	Pending investigation	1 ☐ Inpatia 28e. Date of Injur (Month, Day	y 2	NOutpetians Bb. Time of Injury		8c. Injui Woi	4 Mursi	ng Home 5 28d. Des		nce 6 ∐Othe v Injury occurr)	
The state of the s	Certifica		Could not be determined	28e. Place of inju- building, etc	ry - At home: (Specify)	e, farm, stre	et, factory	, office			ation (Stre or Town,		er or Rura	Route Number,	
1	edicai	29a. Certifier 1 (Check only one)	Certifying Phys Medical Examin	Ician: To the best of er: On the basis of end manner ste	axaminetion	dge, death end/or inv	occurred estigation	at the tir , In my o	me, dete end p ppinion, death o	lece, end due occurred at that	to tha ceu	use(s) and me te end place, o	nner es st	eted. the ceuse(s)	
	0		f certifier	oria marinor sto	100.		290	. Licens	e number		29	d. Dete signed	d (Month, l	Day, Year)	
100		29b. Signature end title o	CONTINO								1				
		29b. Signature end title o	A	1. Elm	Lt M	0		04	5568			3/2/	98		
	Σ	Bons	york.	1. Σluy mplated causa of de		3a) (Type, F	Print)		5568 RD.	has		3/2/	98	226	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day Yea 25 RITA SILVERMAN FEB 1998 6:40 PM 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) TOWSON BALTIMORE ST. JOSEPH HOSPITAL If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) DEC. 5, 1929 9. Birthplace (State or Foreign 5. Sociei Security Number 7. Age (In vrs. last birthday) 1 M 2 XF Months Days Hours Min MARYLAND Yrs. 68 217-24-2090A Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 USA 2533 FARRINGDON RD. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ZÃNo If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Stetus Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) SECRETARY TILE CO. 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) **GLASS** HELZNER ANN HARRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2533 FARRINGDON RD. BALTIMORE, MD 21209 19a. Informant's Name/Relationship (Type, Print) 2533 FARRINGDON RD. SIDNEY SILVERMAN (HUS.) 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ ¥urial 2 ☐ Cremetion 3 ☐ Removal from State 3/1/98 BALTIMORE, MD MTKRO KODESH-BETH ISRAEL 4 □ Donation 5 □ Other (Specify) 21. Signature of Fyheral Service License 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 Approximete Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Brythum Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last lunghory osih, Due to (or as a consequence of) olar Cursinous Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD

Director

Funerai

þ

Completed

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show may injury or other traumatic event, the Magical Examinest must be notified at page.

Baltimore, Maryland 21215-0020

Examiner physician and the burial-transit Physician/Medical attanding p ö signed by the a d be datached f þ should should Completed s cartificata has I diractor, Be Certification: To this funaral Aftar

The law requires that the death cartificate be executed Hospital or Attending Physician: death. after death Director: A

Division of Vital Records. P.O. Box 68760.

To the Hospital or within 24 hours aft To the Funeral DI complately filled in

State

Registrar

Medical 29b. Signature and title of certifier 1. Jehwar

25. Wes case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1□ Yes 2□(No

27. Menner of Deeth

1 Naturei 2 Accident

3 Suicide

29a. Certifier

4 Homlcide

28a. Date of Injury (Month, Day Year)

29c. License number

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

TOWSON, MD

1 ☐ Yes 21 No

2 No

1 Yes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MITCHELL SCHWARTZ, M.D. 31. Date filed (Month, Day, Year)

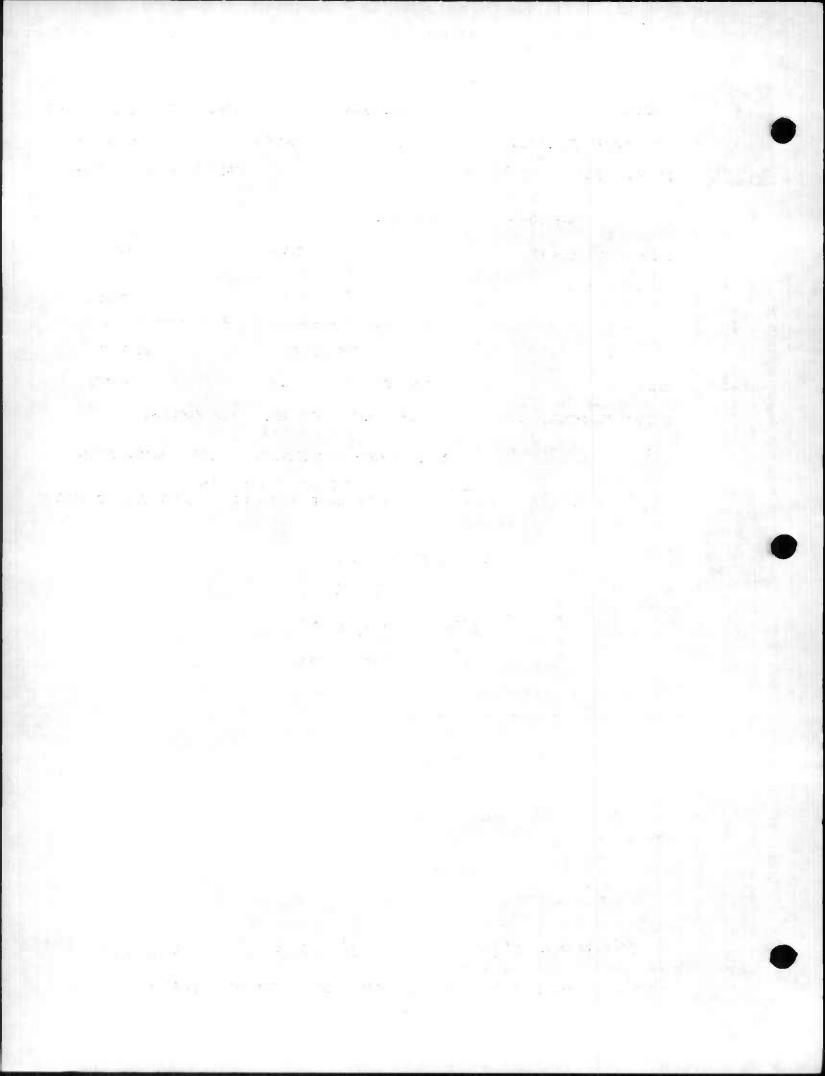
MAR 0 3 1998

6569 N. CHARLES ST., SUITE 407 32. Afgistrer a Signature Randall

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death Dey Yae Month **Physician** Seymour Jay February 25 1998 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner Hospital Baltimore Sinai N/A If Undar 1 If Under 24 Hrs. 5. Soclei Sacurity Number 6. Sax 7. Aga (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min. 067-09-4326 Director 79 AUG. 16, 1918 NEW YORK Usuel Residence of Decedent the Marylend 10a. Stata 10b. County ahow 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahov Director 1 Ves 2 No BALTIMORE RANDALLSTOWN 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3801 SCHNAPER DR., APT. 202 21133 USA deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Maritei Status 14. Race - Amarican Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after nent of Health end Mental Hygiene. I □ Yes 2 □ **X**o If Yes, Give 1 Never Married 2 Married 6 21215-0020 1 ☐ Yas 2 ☒ No Specify: þ WHITE 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) **PHOTOGRAPHER PHOTOGRAPHY** Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) 27 is marked or traumatic even EMIL COHEN ROSE To STARK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
APT. 202 19e. Informent's Neme/Relationship (Type, Print) APT. 202 SCHNAPER DR., RANDALLSTOWN, MD nt of Health e 3801 LUCILLE SEYMOUR (WIFE) 21133 20b. Plece of Disposition (Name of cemetery, crematory or othar place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriei 2 Cremetion 3 Ramoval from State permit. Page Depertment of Important: If any Injury or once. DRUID RIDGE 2/27/98 PIKESVILLE, MD 4 ☐ Donetion 5 ☐ Other (Special 21. Signeture of Funeral Serv SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiretory errest, List only ona cause on each line. 23a. Part1. Enter the disease shock, or heart feilurg. **Approximete** Intervel Between Onset end Deeth **Physician** /Medical immediete Cause (Fire I Pneumonia diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Renal Failure The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest buriel-tran Due to (or es e consequença of) Box 68760. Lymphocytic Leuleemin Chronic Physician/Medical the Dua to (or es e consequance of): 88 use Po P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contribute to the cause of death? detached cate has been signed by , page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings eveileble prior to Completed 24a. Wes en eutopsy completion of causa of deeth? 1 ☐ Yes 2 ☐ No 1 Yas 2 No certificate Vital Physician: director. Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 2 ER/Outpetient 3 DOA of this funeral 28c. injury et Work? To the Hospital or Attending Privating 4 hours after deeth.
To the Funeral Director: After the completaly filled in by the funeral Certification: 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred Division 1 Naturei 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28a. Placa of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide edical 29a Certifier 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, and due to the ceuse(s) and menner steled. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AS-2402321- JR9494 February 25 1998 Do Moremon 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 2501 West Belvedere Avenue Bultimore JRosemore Sinui HOSPITA1 32. Registrer's Signature maryland 31. Dete filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month William E. Sullivan. Sr. FEBRUARY 26, 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Fallston General Hospital Fallston Harkord 6. Sex 1∭ M 2□ F If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) V. Carolina 7. Age (In yrs. last birthday) Days Hours 79 215-07-3145 Yrs. N. Usual Residence of Deceden 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Fallston 1 Yes 2 No Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21047 711 Sharps Court U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Detes: WW 7.7 Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Mechanic and Owner Gas Station 10th grade 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Lucy Seumour William E. Sullivan 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 711 Sharps Ct., Fallston, MD 21047 William E. Sullivan, Jr. (son) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/2/98 Moreland Memorial Park Baltimore. Maryland 22 Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Ferrice Licensee 9705 Belair Rd., Baltimore, MD 21236 23e. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or es a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Tyes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

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State Registrar

31. Date filed (Month, Day, Year)

29a, Certifier

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end manner as slated.

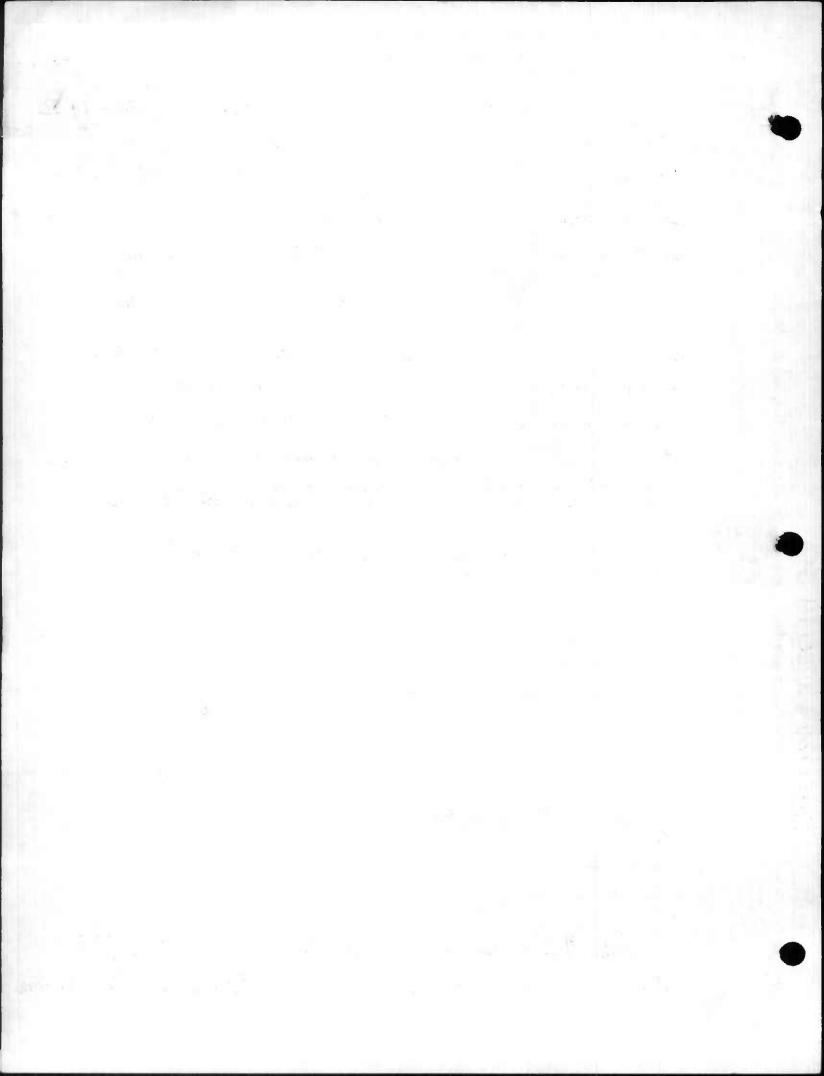
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the ceuse(s) and manner stated.

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emmosta Rd Str 114 2021-B

Ma 21015 Stephen Smaldon

32. Registrar's Signeture Davidson



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Dev Year **Physician** Helen Smullin February 24 1998 7:35 A.M. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Daath 4c. County of Death **Examiner** Frederick Villa Nursing Center Catonsville Baltimore 8. Data of Birth (Month, Day, Year) Jan. 30, 1922 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. **Funeral** Months Deys Hours 1 □ M 280 F 219 12 9309 Yrs 76 Director Maryland Usual Rasidance of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Baltimore Catonsville 1 ☐ Yas 2 No Director 10e. Street end Number Frederick Villa Nursing 10f. Zip Coda 10g. Citizan of What Country? 711 Academy Road Center 21228 U.S. Funeral death 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forces? 11. Marital Status 14. Race - American indian, permit. Pages 1 and 2 should be filed within 72 hours effer 1 Department of Heelih end Mentel Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinations. Black White atc 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva altimore, Maryland 21215-0020 1 ☐ Yas 21X No Specify: Specify: g 3℃ Widowed 4 Divorcad White Completed 16a. Decedant's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elemantery/Secondary (0-12) Collage (1-4or 5+) Homemaker Own Home 12th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) Be Helen Camile Lafae 2 Robert Harrison 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 379 South Drive William Smullen Jr. / nephew Aberdeen, Maryland 21001 20a. Mathod of Disposition 20b. Place of Disposition (Nama of Data 20c. Location - City or Town, Stata cematary, crematory or other place) 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 2/27/98 Laurel, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Md. National Mem. Park 21. Signatura of Funeral Servica Licensae 22. Nama end Addrass of Fecility Gonce Funeral Home P.A. premuourde Lecome 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Entar the disaase, or complications that causad tha daath. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or haart failura. List only ona causa on aach lina. Approximata Intervel Batween Onset and Death **Physician** Myocardial Infaction Immediata Causa (Final diseese or condition resulting in daath) /Medical wood Examiner Examiner ettending physician and for use es the buriel-transit requires that the death certificate be executed Sequantially list conditions, if eny, leading to immadiata ceusa. Entar Undarlying Ceuse (Diseesa or Injury that Initiated avants rasulting in daath) Lest Due to (or as a consaquance of): Records, P.O. Box 68760. Physician/Medical Dua to (or as e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? heart failure 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed to by 24b. Wara autopsy findings eveilebla prior to complation of ceusa of deeth? Completed rouic rend failure 24a. Was an autopsy performed' 1 ☐ Yas 2 00No 1 Tyas 2 SeNo certificate Division of Vital i or Attanding Physician: after death. Director: After this certifica 25. Wes cesa rafarred to medicel examinar? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 10 1 Yas 2 No 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 27. Mennar of Death 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred Certification: 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 ☐ Suicida 6 Could not ba detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, fectory, offica building, atc. (Specify) 4 ☐ Homicida To the Hospital
Within 24 hours a
To the Funeral Completely filled Hospital 29a, Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. Medical (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Date signad (Month, Dev. Year) February au 24,1998 30. Neme and address of person who complated cause of death (Item 23a) (Typa, Print) 7845 Road Dakwood DR. OCHANEJ Suite 205 Burnie, MD 21061

State Registrar

31. Data filed (Month, Day, Yaar)

32. Registrer's Signatura who Davidson

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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth FERRUARY 10:16 AM SLED2 HARLES 25 1888 4b. City. Town, or Location of Daath 4e Fecility Name (If not institution, give street and number) 4c. County of Deeth CENTER BALTIMORE N/A MUSPITAL MANBOR If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Sociel Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 1**M**M 2□ F Months Days 215 03 2289 89 Yrs 1909 1, Maryland Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yas 2 No Maryland Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Coda 10g. Cifizan of What Country? 124 Park Road 21122 U.S. 12. Was Decedant Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxicen, Puerto Ricen, atc.) 14. Race - Amaricen Indien, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dates: 1 ☐ Never Married 2 Merried 1 Yas 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation 16b Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamentery/Secondary (0-12) Collaga (1-4or 5+) Foreman Waterfront 8th 18. Mother's Nama (First, Middla, Meiden Surnama) 17. Father's Name (First, Middla, Last) Peter Sledz Helena Krasniewski 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) Margaret Sledz / wife 124 Park Road Pasadena, Maryland 21122 20b. Place of Disposition (Nama of cematary, crametory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Buriel 2 □ Cremation 3 □ Removel from State Glen Haven Memorial Park 2/28/98 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signeture of Funaral Sarvice Licensea 22. Nama end Address of Fecility Gonce Funeral Home P.A. musuren brea 4001 Ritchie Highway Baltimore, Md. 21225 23a. Den 1. Entar tha disease or complications that ceused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death Immediate Causa (Fine) ARDIAC 1) AYS disaasa or condition rasulting in daath) Dua to (or as a consequence of) Sequantially list conditions, if any, laading to immadiate ceusa. Enter Undarlying Causa (Disaasa or Injury that initiated evants resulting in death) Lest Dua to (or as a consequence of) Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 D Onknown sho want 24b. Wara autopsy findings evailable prior to complation of ceusa of daath? 24a. Wes an autopsy performed? CARDIOMEOPATHY KEMA ALLURE 1 Yas 219 No 1 □ Yas 2 PNo 25. Was cesa referred to medical exeminer? 26. Pleca of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 27. Menney of Deeth 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work?

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Baltimore, Maryland 21215-0020

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(Check only one) 29b. Signeture end little of certified

1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, end due to the cause(a) end mennar es steted. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29c. License number 29d. Date signed (Month, Day, Year)

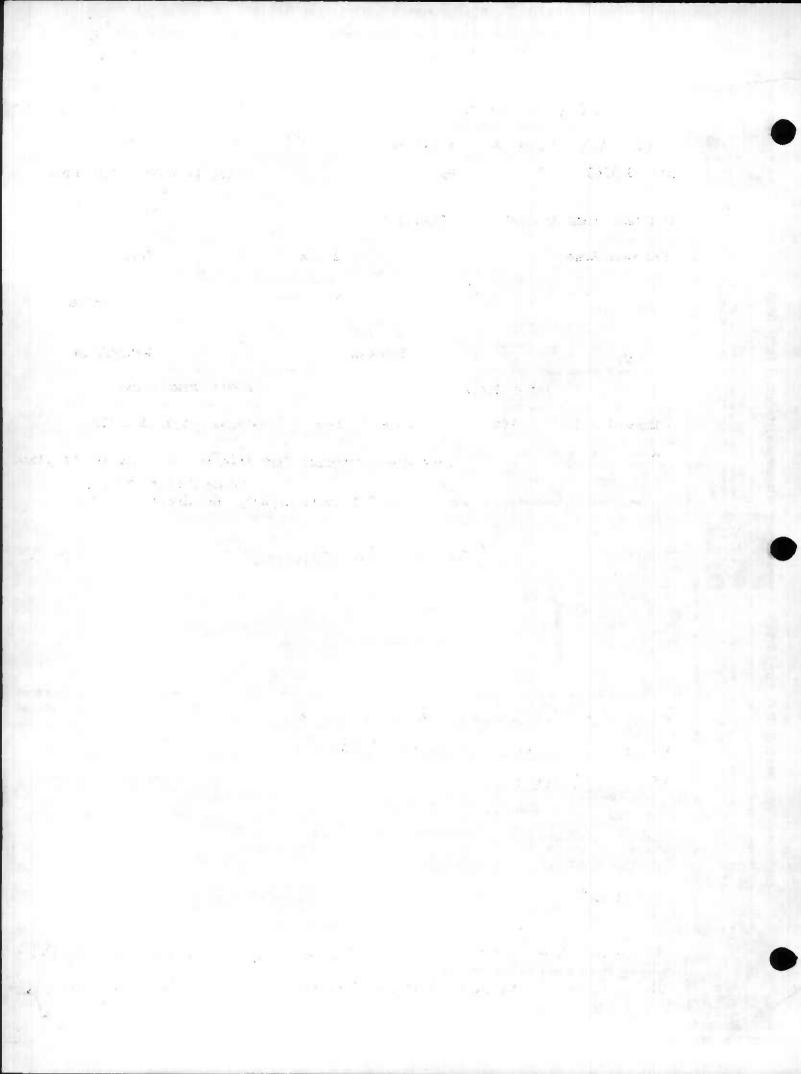
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30. Name end eddrass of person who completed causa of death (Itam 23a) (Type, Print)

hanson JASVINDER MAWLA Julia Day Gon Randell

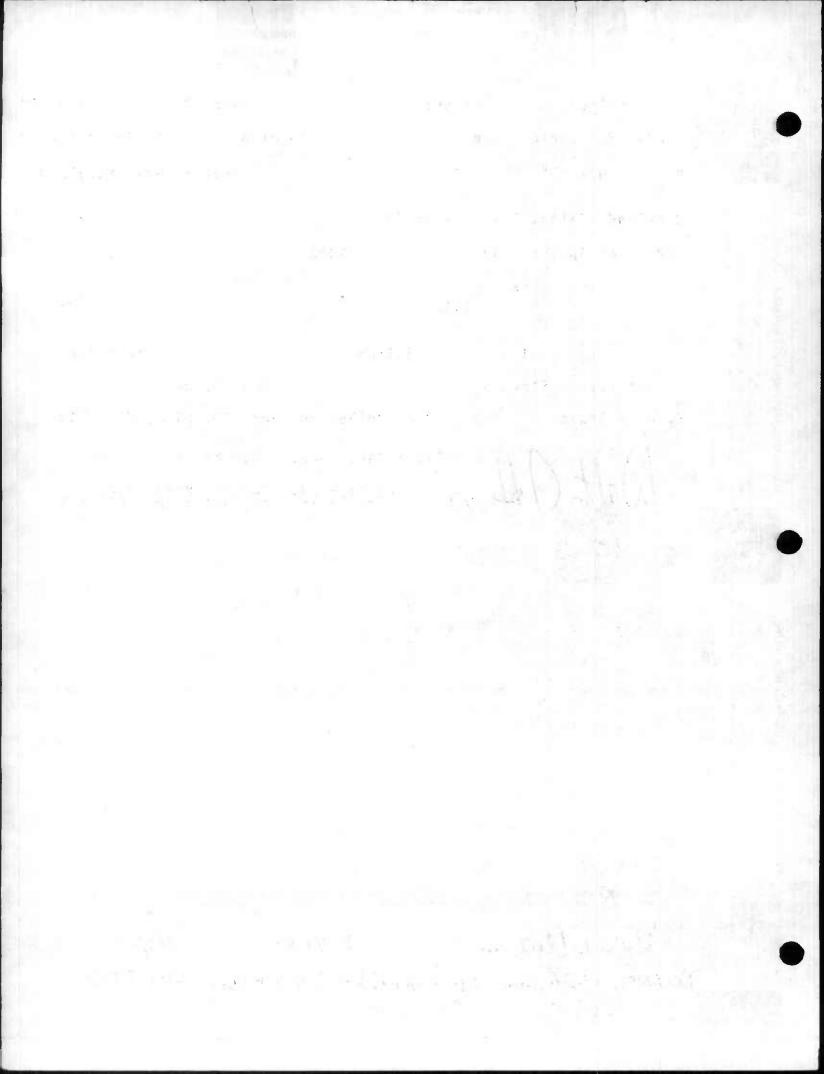
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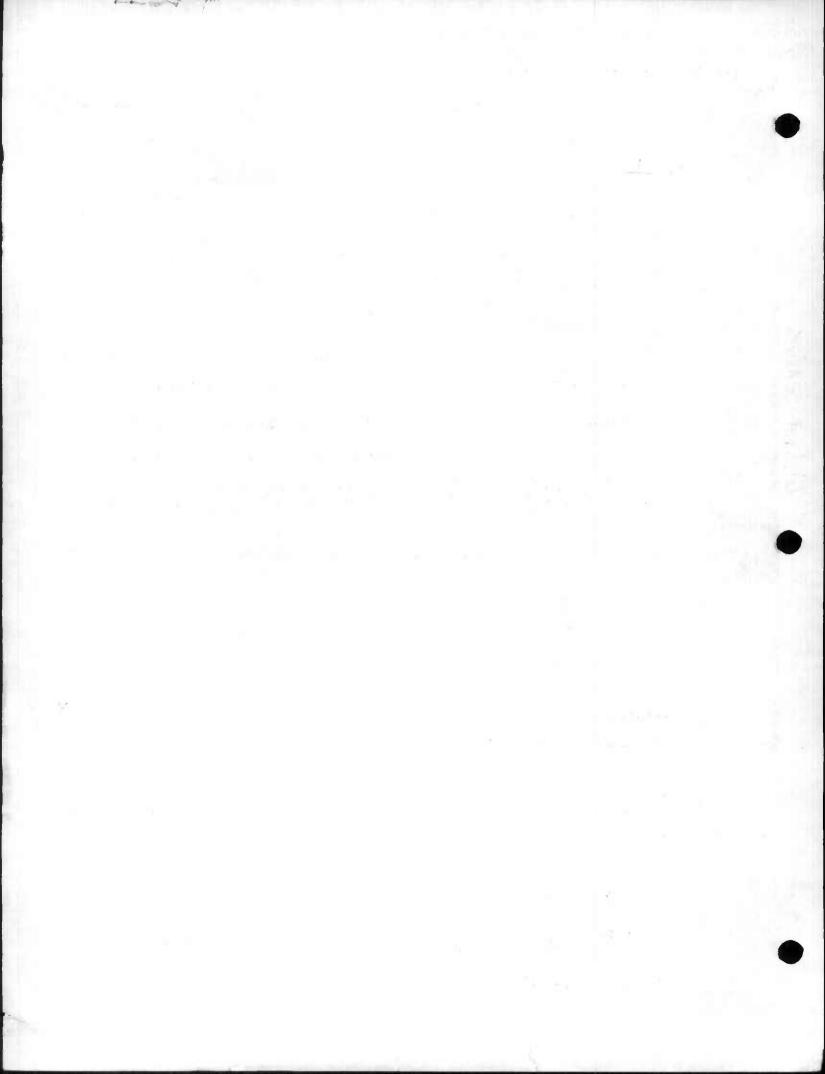
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pletely fill	2	9a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exami	eiclan: To the best of nar: On the basis of end menner ste	examinetion end	deeth occurre Vor investigetion	d et the tim	e, dete end plece pinion, deeth occur	, end due to the corred et the time, d	euse(s) end me ete and plece, o	nner es stete and due to the	d. e ceuse(s)			
E Z	2	9b. Signeture end title of certifier	1 ~1		2	9c. License		2	9d. Dete signed	(Month, De)	r, Year)			
		* Koland U	Uh NA				7150		3/3/	98				
	3	D. Name end eddress of person who co	mpleted ceuse of de	eth (Item 23e) (1447)	Type, Print)	RD.	LUTHER	VILLE	MD.	2109	13			
State	3	1. Dete filed (Month, Dey, Year)	32. Registre	r's Signeture	S									

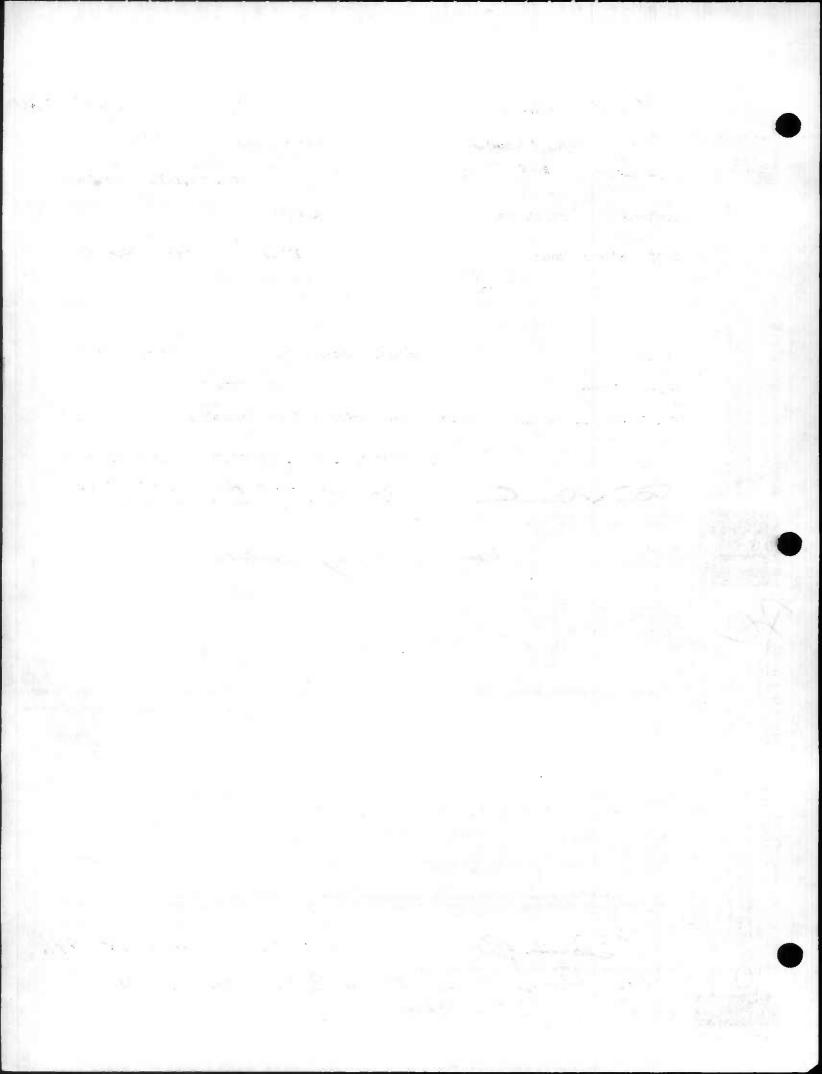


State of Maryland / Department of Health and Mental Hygiene

Ite	n#5	per FH G	758 4/6/		viai y iai		Certificate	of Death	, workarr	Reg. No.	Ub	551
Physic /Medi	ian	1. Decedent's Nem	e (First, Middle, L		itch	ie S	Semans.	Jr.	2. Dete of I Month MARC	Death Day	Year	3. Time of Deeth
Exami			If not institution, gi	ve street end numb			,		or Location of De	eth 4c. County		
Funeral	H	Gilchri 5. Social Security N	lumber 6.	Sex 7.	Age (In yrs	lest birti	hday) If Under 1		Irs. 8. Dete of E	Birth	altimo	e (Stete or Foreign
Director		215 61 Usual Residence o	TOOT	J□M 2□F	79	٧	rs. Months	Days Hours M		Day, Year)), 1919	Country, Maryla	
nylend how	_	10a. Stete	10b. County		10c. C		or Location				10d.	Inside City Limits
ha Ma 28s-1	Director	MD 10e. Street end Nu	N/A			ва	ltimore	12 d		140.000		tv Yes 2 No
ath with	rai Dir	10 Kno1		Court				1210		10g. Citizen of USA		
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mantal Hygiana. "Intervent: or flems 23a or 28a-1 show any injury or other traumetic event, the Marclast Exemines matter as any injury or other traumetic event, the Matters Exemines training as notified as angles.	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied Ž(Divorced	12. Was Decede Armed Force 1 DXYes 2 If Yes, Give Year or Dete	os? □ No WW	ı,s. II	13. Wes Decede If Yes, specif		of Hispanic Origin? (Specify Yes or No- uben, Mexican, Puerto Rican, etc.) Specify:		14. Race - American In Bleck, White, etc. Specify: Whit	
5-0 72 ho	eted	(Spec	15. Decedent's E	ducation rede completed)		16a.	 Decedent's Usuel Occupetion (Give kind of work done during most of workin life. DO NOT use retired) 			16b. Kind of B	usiness/Indus	try
Maryland 21215-0020 d.2 should be filed within 72 hours eff th and Mantal Hygiana. The marked other than "naturel", or traumatic event, the Madical Exert	Completed	Elementary/Second 1.2	ondary (0-12)	College (1-4	or 5+)		<i>life. DO NOT</i> use Leet <u>Ma</u> j			Car I	ealer	shin
ind ind tal Hy d other	Be	17. Father's Name						18. Mother's N		lle, Meiden Sumer	ne)	1
ryla Men marks	2	William Ritchie Semans, Sr. Anne Elizabeth T 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town,										
Ma Md 2 s Mith an 27 1s r		Ann C. Se						idge Ct. B			200	(06)
Baltimore, A Baltimore, A Baltimore, A Bopartment of Health Important: If then 27 any injury or other tangents.			Cremation 3	Removal from Sta		Place of cemeters	Disposition (Neme	of er plece)	Dete	20c. Location	City or Town	
oit. Pa		4 ☐ Donation 21. Signature of Fu	5 Other (Speci	**	Me	LLO		y, Inc. 03 Address of Fecility	703/98	Baltin	nore, N	10
Ball Ball Depariment impon			11/110/1/	1/11/1/ Imm	ald		Cromot	iam Casis	ty of Ma	ryland,	Inc.	
	- 1	23e. Part1. Enter t shock, or hea	he diseese, or con ort failure. List only	polications that ceus	sed the dea h line.	th. Do n	ot enter the mode	ederick Roof dying, such as cerd	liac or respiratory	arrest,	AL 440	pproximate tervel Between
Physician /Medicai	1	Immediate Ceuse	(Final									A Y &
Examiner		disease or condition resulting in death)	òn	e. WE			onsequence of):	ra of twi	Pnaeus			416
2 =	iner			b	20010 (
58760, cata be axecuted physician and s the burial-transit	Examiner											
68760, ficata be av physician is the buria	edicai E											
⊕ 50 €	1 400	resulting in deeth) Last d								*		
cords, P.O. Box requires thet the death card been signed by the attending should be detached for use	Physician/N	Part II. Other signif	itcant conditions	contributing to deat	h but not res	sulting in	the underlying ceu	use given In Pert t.	23b. Di	d tobacco use co	ntribute to th	ne cause of death?
P.O. het tha de de by the a datached		HYPERSE	4						1[Yee 2□ No	3 Probab	oly 4 Unknown
ds, uires th	d by	0.	3,67-	Acc. Jes.					24e. W	es en eutopsy		eutopsy findings
aw aw	Completed	Cereor	YASCULIKE.	ACC. Jest					pe	rformed?	comp of dee	ble prior to letion of ceuse eth?
Vital Rec	Com								10	Yes 2000	1 🗆 Y	'es 200 No
of Vita Physicien: this certific	Be	25. Was cese refer examiner?		Hospital:				0	Death (Check onl			
Phys rthis arai dia	To To	1 ☐ Yes 2 📜		1 □ Inpo	njury	ER/Out	petient 3 DOA	. Unjury et Work?	1	esidence 6 NOtt		الثاريث
Division of Vital Records, to the Hospital or Attanding Physician: The law requires the Within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be	Certification:	1 Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 Pending investigation 6 Could not be determined	(Month,	Dey Year)	In ome, far	m, street, factory,	1 ☐ Yes 2 ☐ No	28f. Location	(Street and Num.		loute Number,
Dispital or ours after our after in filled in		29a. Certifler	1M Certifying Pi				death occurred at	the time, dete end ple			annar as state	2d
othe Hospital ithin 24 hours othe Funeral I	edical	(Check only one)	2 Medical Exa	miner: On the basis and manner	of examine	etion end	Vor investigation, li	n my opinion, death oc	ccurred at the tim	e, date end plece,	end due to th	e ceuse(s)
To the com	Σ	29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12399 12399 12399										
		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Charles Onderical In, my 6525 N. Charles St. \$509 3027, make, my 21224 31. Date filed (Month, Dey, Year) MAR 0 3 1998 Julia Paridson—Randelle										
Sta	ate	31. Date filed (Mon	th, Dey, Year)	32. Regi	strer's Sign	ature	Commence 37	201	- (14.44	- 1		
Regist	rar	MAR 0	3 1998	gulia la	Vidson-	gande	22					



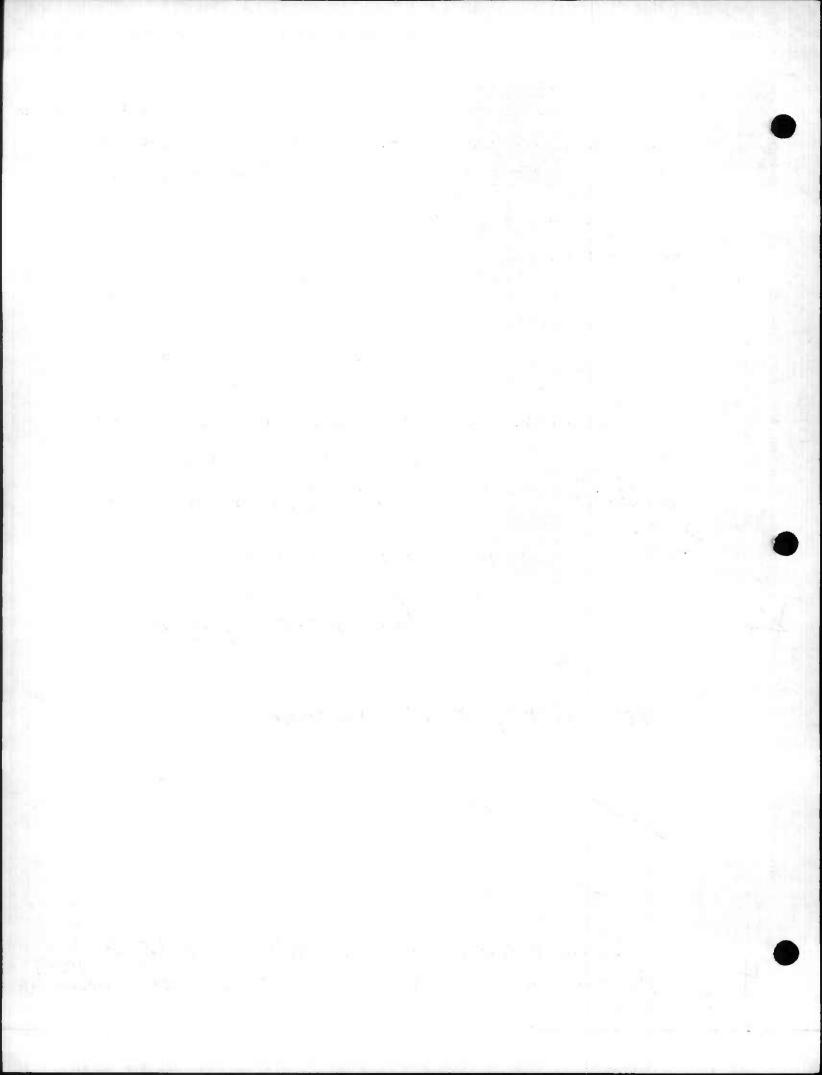
		Decedant's Nema (First, Middla, L.)	ast)		Cer	tificate of	Death	2. Date of Da	Reg. No.	3. Time for th
hysiciar /Medica	_	Mardel Su	ichko					Month	Day_	Yaer 1998 115 AM
xamine	_	4a. Facility Nema (If not institution, gin					4b. City, Town, or 1 Balt/mo	ocation of Deal		
nerai ector		5. Social Sacurity Number 6. : 215–14–5207		Aga (In yrs. las	t birthday) Yrs.	If Undar 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Bir (Month, De	rth ay, Year) 28,1922	Birthplece (State or Foreign Country) Maryland
M til	-	Usual Rasidanca of Decedant 10a. Stata 10b. County		10c. City, 1	Town or Loc	ation				10d. Inside City Limits
The day	Tor	Maryland Ba	ltimore				Dundalk			1 ☐ Yas 2 ☐ No
Example must be notified at		10e. Street and Number 3449` Dunhaven Ro	bed			10f. Zip Coda	21222		10g. Citizen of W	
Financial	Funeral Director	11. Marital Status 1 Navar Marriad 28 Married	12. Was Dacad Armed Forc 1 Yas X	as?		/as Dacedant of I Yes, specify Cub	dispenic Origin? (S an, Mexican, Puart	pecify Yes or No o Rican, atc.)	o- 14. Rece Black	- American Indien, c, Whita, atc.
100	ed by	3 ☐ Widowad 4 ☐ Divorced 15. Dacadant's E	Yaar or Det			ant's Usual Occup	Spacify:		Specify:	White
feinmo	Completed	(Specify only highest gra Elemantary/Secondary (0-12) 8 Years	College (1-4		(Giva k lifa. D	ind of work done O NOT usa retire	during most of word		Sec. 18	L Safety
9		17. Fathar's Name (First, Middla, Last)						, Maidan Sumema	a)
To Be	0	Robert Young						Korte		
		19a. Informant's Name/Ralationship (Mr. Andrew S. St		Husband			end Number or Ru en Road	Dundal	er, City or Town, S k, Maryla	Stete, Zip Code) and 21222
		20a. Mathod of Disposition 1X Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specil		ete cem	atary, crem	ition (Nema of atory or other pla- 11 Mem.	Gdns. 3/	Deta 3/1998		City or Town, Stata
ouce.		21. Signature of Funarel Sarvice Lice	nsaa		I		k Funeral			
	1	23a. Part1. Entar tha diseasa, or com shock, or heart failura. List only	plications that cau	sad tha daath.	Do not anta	1922 Wise r the mode of dylr	e Ave. D	or raspiretory a	Marylan ırrast,	d 21222 Approximate Intervel Between
ian cal ner		Immediata Cause (Final disaasa or condition resulting in death)		Dua to (or a	per	learning		bolen		Onsat and Death
Examiner			b							
1		Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaasa or injury thet initiated avants	c	Dua to (or as						
n/Medical	- 1	resulting in daath) Lest	d	Dua to (or as	e consequ	ance of):		Q		
Physician/M	200	Pert II. Other significent conditions o	ontributing to deat	h but not rasultir	ng In the und	dartving causa giv	en in Pert I.	23b. Did	tobacco use con	tribute to the cause of death?
be deteched for use by Physician/										3 Probably 4 Unknown
Completed b	novoid.							24e. Was perfo	an autopsy ormed?	24b. Wara autopsy findings availabla prior to complation of cause of death?
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To Be	3	25. Was casa raferred to madical exeminar? 1 □ Yas 2 □ No	Hospital:	Slient 2∏ED	/Outpatient	3□ DOA Oth	26. Place of Dea		ona) dance 6 □Otha	(Caralti)
		27. Mennar of Deeth 1 ☐ Natural 5 ☐ Panding 2 ☐ Accidant invastigation	28a. Dete of I (Month,		b. Tima of Injury	28c. Injur Wor			how Injury occurre	
Certification:		3 Suicida 6 Could not be datarmined	28a. Place of	Injury - At homa etc. (Specify)	, farm, strae	et, fectory, office		28f. Location (: City or Tox	Street and Numbe wn, Steta)	r or Rurel Routa Number,
edical (29a. Cartiflar 1 ☐ Certifying Ph (Check only one) 1 ☐ Medical Exam	ysician: To the be niner: On the basis and manner	s of examination	dga, death o and/or Inva	occurrad at tha tin stigetion, in my o	ne, data and place, pinion, daath occur	and due to tha red at the tima,	causa(s) end man data and place, ar	nar as stated. nd dua to the causa(s)
Σ		29b. Signatura and titla of certifier		>		29c. Licans			29d. Data signed	(Month, Day, Year)
		1 Celebra	and!)		Di	14147		Feb	28 1998
		30. Name and address of person who	complated cause of	of deeth (Itam 23	(Type, P	rint) 2/ St/	Paul Pl	Barr	(como	40
State egistrar		MAR 0 3 1998	Luka Jeu	strer's Signature	Lece.					



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Ī	. Decedent's Name	a (First, Mide	da, Last)			00	rtificate of	Joan	2. Data of Da	Reg. No.	3	Tima of Death
sician	ı	Emelin	20	McC1a	ain		Shollow			Month	Day	Yaer	
edical miner	4	a. Facility Nama (#					Shelley		4b. City, Town, or	FEBRU Location of Deat			1:40 A
		REATER	BAT.T	TMORE	MEI	TCAT.	CENTE	P	TOWSON			IMORE	
ral	_	. Social Security No		6. Sex			rs. lest birthday	If Undar 1 Yaa	r If Under 24 Hrs				(State or Foreign
E .	-	213-42-68		1 🗆 M	2□ F	78	Yrs.	Months Days	Hours Min		7 1919		Carolina
		Isual Residence of Oa. Stata	Dacedant 10b. Count	<u> </u>		100.6	City, Town or Le	ocation					
5		MD		timore		100.							nside City Limits □ Yas 2√□ No
Director	-	0e. Street and Nun		CIMOL	2		Cockey	10f. Zip Code			10s Chines of		X
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Funeral	1	1. Maritel Status	nacio			dent Evar In	U.S. 13.		030 Hispanic Origin? (S	Specify Yas or No	USA 14. Bas	ta - American Ir	ndian.
by		1 ☐ Naver Marria		rried	Armed For 1 ☐ Yas If Yas, Giv Yaar or Da	2 No		if Yes, specify Cu 1 ☐ Yas 2 ☑ No	Hispanic Origin? (s ben, Maxican, Puer Specify:	to Rican, atc.)		white, atc.	
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Be	1	7. Fathar's Nama (First, Middle	, Last)						ma (First, Middle	, Maidan Suman	na)	
2		Bert (a Smith			
	1	9a. Intormant's Ne				Com		-	et end Number or R				(a)
	2	Jerry De. Mathod of Disp		e Silei	Liey/			osition (Nema of	omley Rd.	, Inurmo		- City or Town,	State
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any injury once.	2	1. Signature of Fig.	aral Servici	Licentee)		2. Nema and Addi	ass of Facility	m.o.			
	1	Carolina P	W.	emmon	ap				ionia Rd.		lum, MD	21093	
Wedical Examiner	or o	mmediata Cause (fisease or condition assulting in death) Sequentially list con any, leading to im ause. Enter Undar ause (Disease or let initieted events seulting in death) L	oditions, madiata riying njury	a b c d	/	Due to	(or as a consact	quanca of): Harring H	Hanction RT DIST	USE	g I Tank	ואו	
iciar	P	art II. Other signific	cant conditi	one contribu	iting to do	ath hut not re	novitina in the co		hina ta Dana t	non Did	4.1	1	
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Completed	-		/								an autopsy ormad?	evailab	utopsy tindings la prior to tion of causa n?
COL										10	Yas 2 No	1 ☐ Ya	s 2 No
Be (2	5. Was casa ratarre axaminar?	ed to medica						26. Placa of De	ath (Check only	one)		
10		1 Yas 2		Hosp	1 1147		☐ ER/Outpatier	I 3LI DOA		Home 5 Resi	dance 6 □Oth	ner (Specify)	
Certification:	2	7. Manner of Deeth 1 Naturai 2 Accident	5 Pandi invast	ng igation	8e. Data o (Monti	t Injury h, Day Year)	28b. Tima o Injury	W	uryat ork?]Yas 2 □ No	28d. Dascribe	how injury occur	Ted	
Certifi		3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, tarm, straet, tactory, office building, etc. (Specify)								28t. Location (City or To	Street and Numb wn, Stata)	ber or Rural Rou	uta Number,
edicai	2	9a. Certifiar (Check only one)	1 Certifyi 2 ☐ Madical	Examiner:	n: To tha l On tha ba and mann	sis of axamir	nowledge, deeth nation and/or In	n occurred at tha t vestigetion, in my	ime, dete end place opinion, death occi	e, and dua to tha urred et the time,	cause(s) and ma date and place,	annar as stated and due to the	cause(s)
Σ	2	29b. Signatura end titla of cartifiar 29c. Licansa number									29d. Data signe	d (Month, Dey,	Year)
			In	Le 7	ave	ella 1	nD.	DA	1407		02/28	198	
	3	. Nama and addre	ss of person	who comple	eted cause	ot death (It	am 23a) (Type,	Print)			1	1 6	71093
State		D. Nama and addre	ss of person	who comple	5 m	ot death (Ita 1 D. Ighstrag's Signal (Italian)	407	Print)	IK RD	Suit	1309	Luthro	1109

Emeline Shelley



Division of Vital funeral director, After

Certification:

edical

5

State

death. or Attendiation after death Hospital c 24 hours at Funeral D To the Hosp within 24 hou To the Fune completaly fi

(Check only one)

29b. Signeture end title of cartifiar

invastigation 2 Accidant 3 Suicide 4 ☐ Homicide

6 Could not be determined

2-28-98

28e. Pieca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

home

nely

~ 900 AM

MO

1 Yes 2 No

O.C.M.E.

Self inflicted gunshet wound 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 607 Stoney Lane Catonsville, Maryland 1 Centifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) and menner es steled.

3. Time of Deeth

9:31A.M.

10d. Inside City Limits

Approximete Intervei Between Onset end Deeth

14 Yes 2□ No

1 ☐ Yes 2 No

2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29c. Licanse number 29d. Date signed (Month, Dey, Year)

MARCH 1,1998

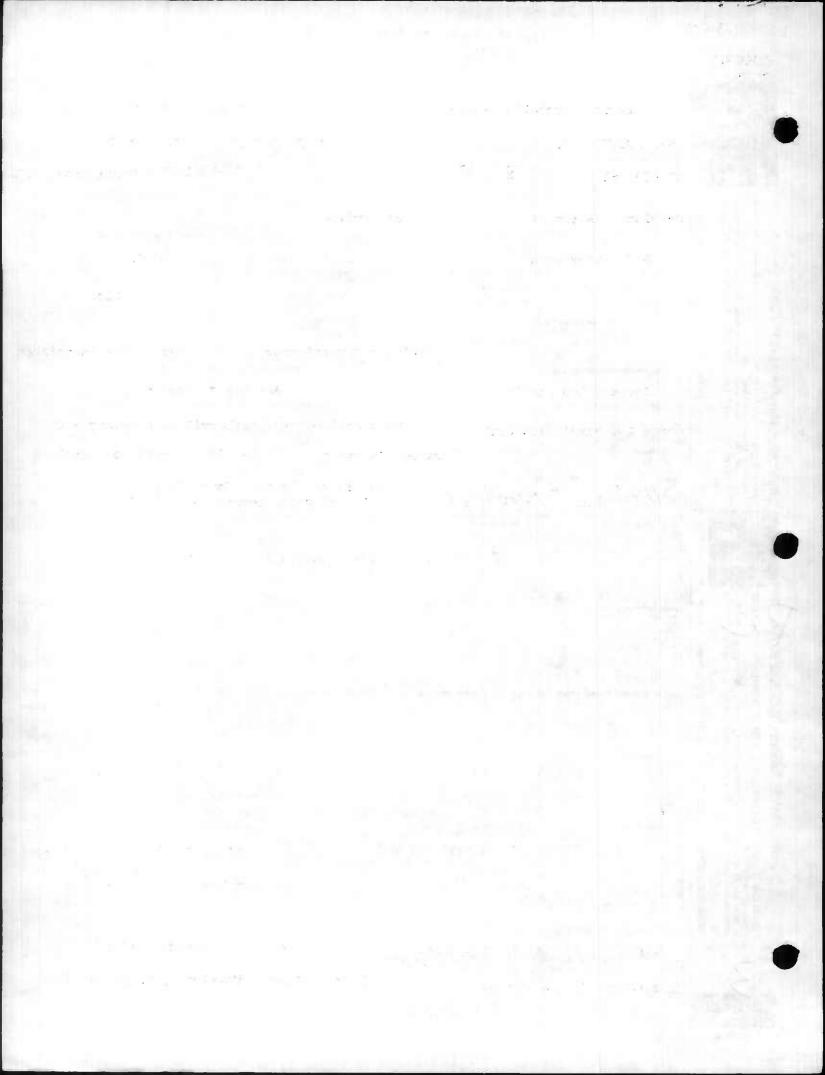
30. Name end eddress of person who completed cause of deeth (Item-23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

Radentz, Strphen S.
31. Dete filed (Month, Dey, Yeer) MO

MAR 0 3 1998

32. Registrar's Signature Didon Randalle

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 1 per M.D G-757 3/3/98 reb 1. Deegdent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death **Physician** Month CV Monroe 18 2220 MONROE SNYDER /Medical 0 4a. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth County of Death Examiner R3 132 Shoc MMS Innov 9 Sums If Undar 24 Hrs. 8. Deta of Birth (Month, Day, 5. Social Security Number If Under 1 Yeer (In yrş. last birthdey) Birthplaca (State or Foraign Country) **Funeral** M 2 F Months Days 185-01-2142 Yrs. Director Pennsylvania 00 Usuel Rasidanca of Decadant with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Exeminar must be notified at 1 X Yas 2 □ No Director PA York Red Lion 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 234 Wise Avenue U.S.A. Funeral 17356 death 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Med cal Exemina 1 ☐ Yas 2000 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2XXNo Specify: Specify: White þ 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 6th Wood Worker Building 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surneme) Phillip Snyder Alice Myers 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 234 Wise Avenue, Red Lion, PA 17356 Grace O. Snyder 20a. Mathod of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) Feb. 26, 20c. Location - City or Town, Steta 1 X Burial 2 ☐ Crametion 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) 1998 Salem Union Cemetery Jacobus, PA Burg Funeral Home, Inc. outsplette Approximate Intervel Betwood of dying, such as cardiac or raspiratory approximate Intervel Betwood Onsat and D 21. Signature of Funaral Sarvice Licansed 22. Nama end Addrass of Facility 134 W. Broadway 17356 23a. Part1. Enter the disease, or complications that courshock, or heart failure. List only one cause on each Mule Intervel Between Onsat and Daath **Physician** /Medicai Immediata Causa (Final disaasa or condition resulting in daeth) Examiner Dua to (or as a consequence of) the buriel-transit death certificete be executed and Sequantially list conditions, if any, laading to Immadiata causa. Entar Underlying Ceuse (Diseasa or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): COVC Division of Vital Records, P.O. Box 68760, physician Physician/Medical use as 10e, signed by the attending the deteched for use as Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown by should 24b. Were eutopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed hes this certificate 1 ☐ Yes 2 No Physician: 25. Wes case retarrad to medical axaminar? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 ☐ Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending 5 Panding Invastigation 1 Naturel 90051 death. 1 🗌 Yas 2 Accident or Attend efter death Director: 3 Suicida 6 Could not be determined 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in CAMOLC CO Descritiving Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and mennar as stated.

I Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) 29a. Certifiar Medical and mannar stated. 29b. Signetura and title of certifiar

29c. Licanse number

30. Nama and eddrass of parson who complated cause of deeth (Item 23a) (Typa, Print)

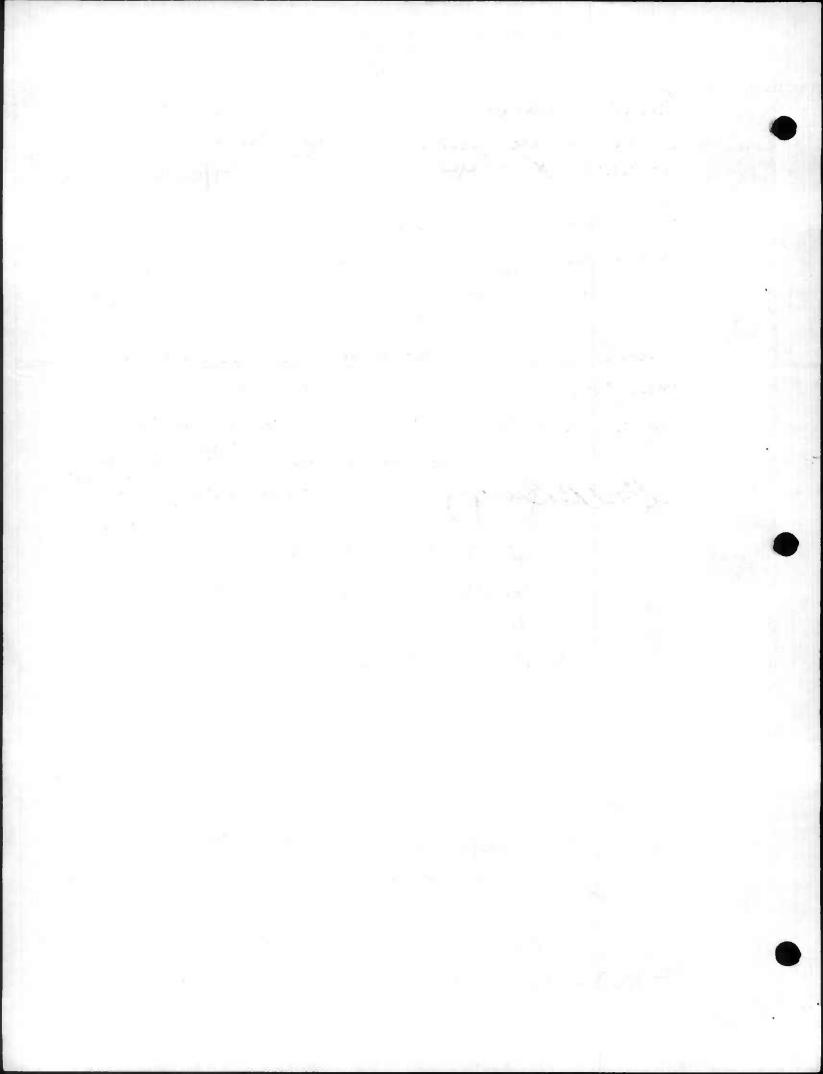
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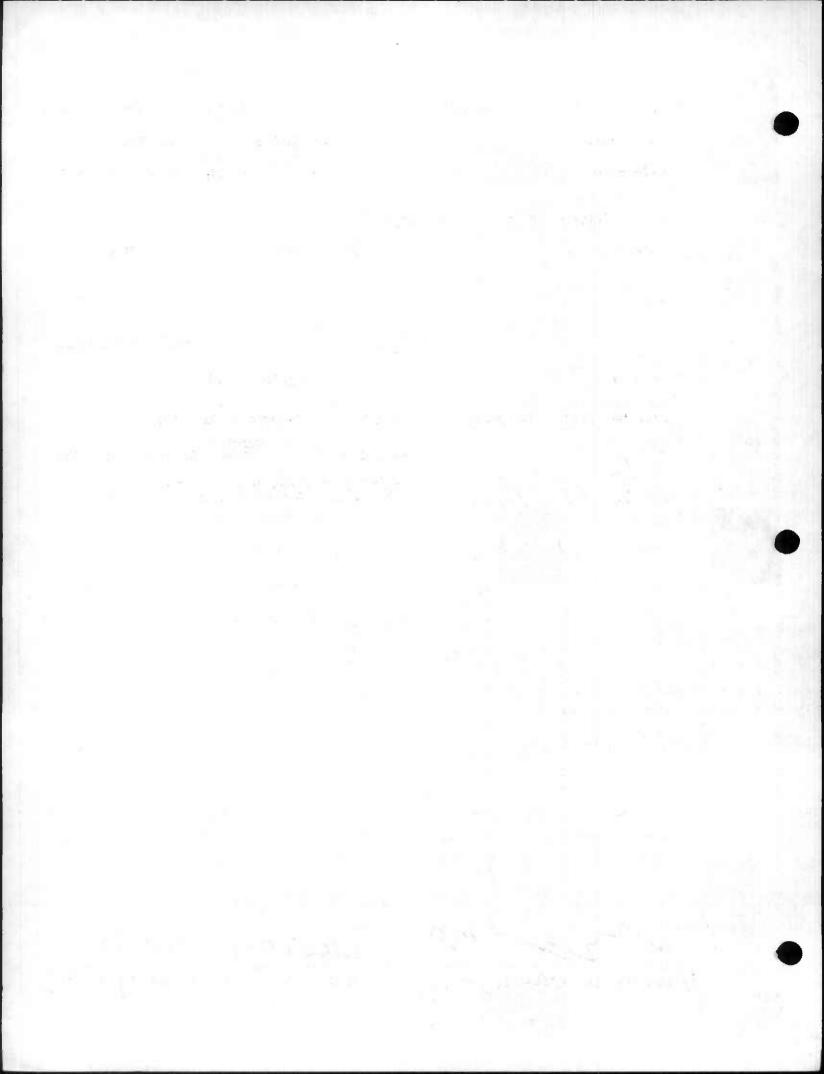
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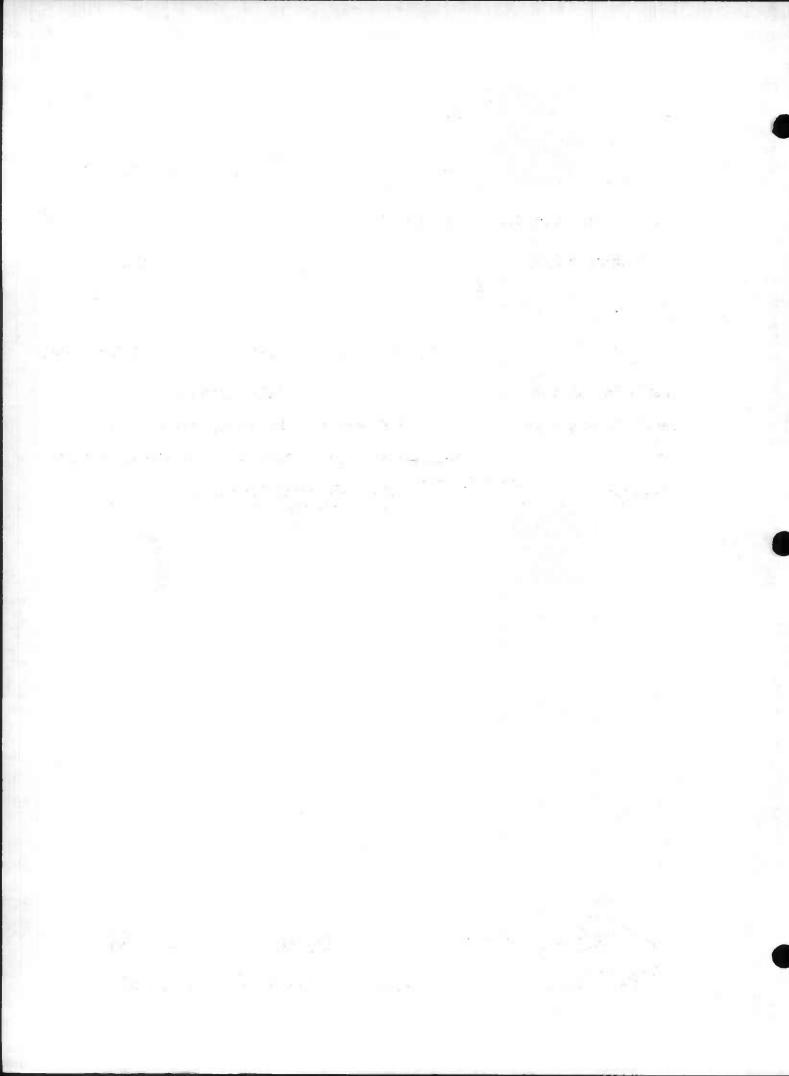
State of Maryland / Department of Health and Mental Hygiene

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J.	/Med	ical	EVELYN A. SCHAEFER 4a. Facility Name (If not institution, give street end number)	Ab Cibe	MARC		998 11:45PM
ч	Exami	ner	10 OAK STREET		, Town, or Location of BRIDGE		
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	land w		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits		
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	th with the 23a or 28a	al Director	10e. Street and Number 10 Oak Street		Citizen of What Country?		
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Maryland	d 2 should h end Men 7 is marke traumatic	F	19a. Informant's Neme/Relationship (Type, Print) 19b. Melling Ac	ddress (Street end Nu	mber or Rurel Route N	lumber, City or Town, Sto	ete, Zip Code)
			Jean Marshall (Daughter) 10 Oak	Street, C	ambridge,	Md. 21613	
Baltimore,	of He		20e. Method of Disposition 1 X Burial 2 Cremetion 3 Removed from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremetor Cedar Hill	ry or other plece)	March 1998		y or Town, State Park, Md.
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee 22. Na MCC 130	me and Address of Fa Ully-Polyn E. Fort A	ilak Funera	1 Home nore, Md. 21	230
			23a. Part1. Enter the disease, or complications thet of used the death. Do not enter the shock, or heart failure. List only one cause on each line.				Approximete Interval Between
Ž.	Physician /Medical						Onset end Death
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90,	rificate be executed ng physician and es the buriel-fransit	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events	lin de	pender	i diabete	s years
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	within To the	Me	00h Cinneture and the of confiler	29c. License numbe	er	29d. Date signed (A	Aonth, Dey, Year)
			1 - 2/	D005	0987	3/2/	98.
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Almeet Vavv / 105 A	mora	Sweet	Cambrid	98. 28.
	Sta Registr	_	31. Date filed (Month, Day, Year) 11. Date filed (Month, Day, Year) 12. Regulara's Signature 13. Date filed (Month, Day, Year)				



State of Maryland / Department of Health and Mental Hygiene

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ore	ges 1 en t of Heal If Itam 2 or other		20a. Method of Disposition		20b. Place of D cematary,	Disposition	(Nama of	ica)	Data		City or Town, Stata	
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E	After thi funeral	Certification:	27. Manner of Death Datural 5 ☐ Panding	28a. Data of Injury (Month, Day Y	(ear) 28b. Tin	ury	28c. Inju Wo		28d. Dascribe	how Injury occur	red	
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	o the	Mec	29b. Signature and title of confiler				29c. Licens	sa number		29d. Data signe	d (Month, Day, Year)	
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			30. Name and address of court sha	pointed course of division	th /ttom 00-1 C	ma Dalas					(10	
			30. Name and address of person who com	VARTZ A		ype, Print)	0/0	17/18 1001+R	Atton	3 0/24	A	
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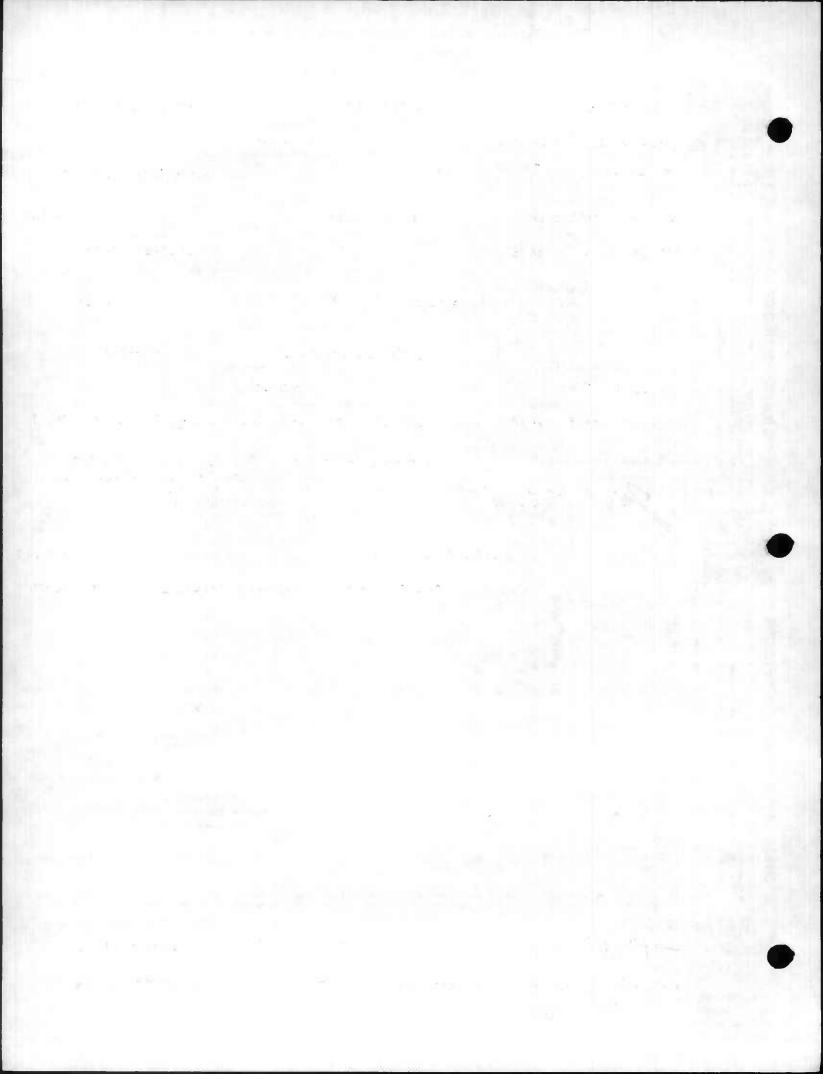


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** STAUFFER RICHARD 1998 01:47A.M. FEBRUARY /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 1 X M 2 □ F 59 Yrs. 505-42-3593 **Director** October 30,1938 Nebraska Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shov traumatic event, the Modical Examinat must be incurred at 1 ☐ Yes 2 X No Owings Mills Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 324 Garrison Forest Rd. 21117 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If them 27 is marked other than "natural", or thems 23 int: If them 27 is marked other than "natural", or thems 23 Funeral 12. Was Decedent Ever in U,S. Amped Forces? 1 ½ Yes 2 □ No If Yes, Give Year or Dates: 1963–67 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ orthopedic surgeon medical 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Joan Gale Harold Stauffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 324 Garrison Forest Rd. Owings Mills, MD 21117 Kathleen Stauffer/wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2/28/98 Baltimore, Maryland Greenmount Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Home & Baltimore, MD int. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** fmmediate Cause (Final disease or condition resulting in death) /Medicai ASPERGILLOS IS TWO MONTHS Examiner Due to (or es a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE TEN YEARS physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): usa Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dfd tobacco use contribute to the cause of death? Division of Vital Records, P.O. the signed by to 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed peen Jas paga 2 1 Yes 2 No certificata 1 ∏ Yes 2 ∏ No or Attending Physician: after death. 25. Wes cese referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomloide To the Hospital washing 24 hours after Technology edicai 29a. Certifier 1🜠 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month, Dey, Year) RES-000 27,1998 FEBRUARY MD 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) KARI ROBERTS MD TOWER 110, 600 N. WOLFE STREET, BALTIMORE, MARYLAND 21287 31. Date filed (Month, Day, Yeer) MAR 03 32. Registrer's Signeture State

Registrar

wha Davidson

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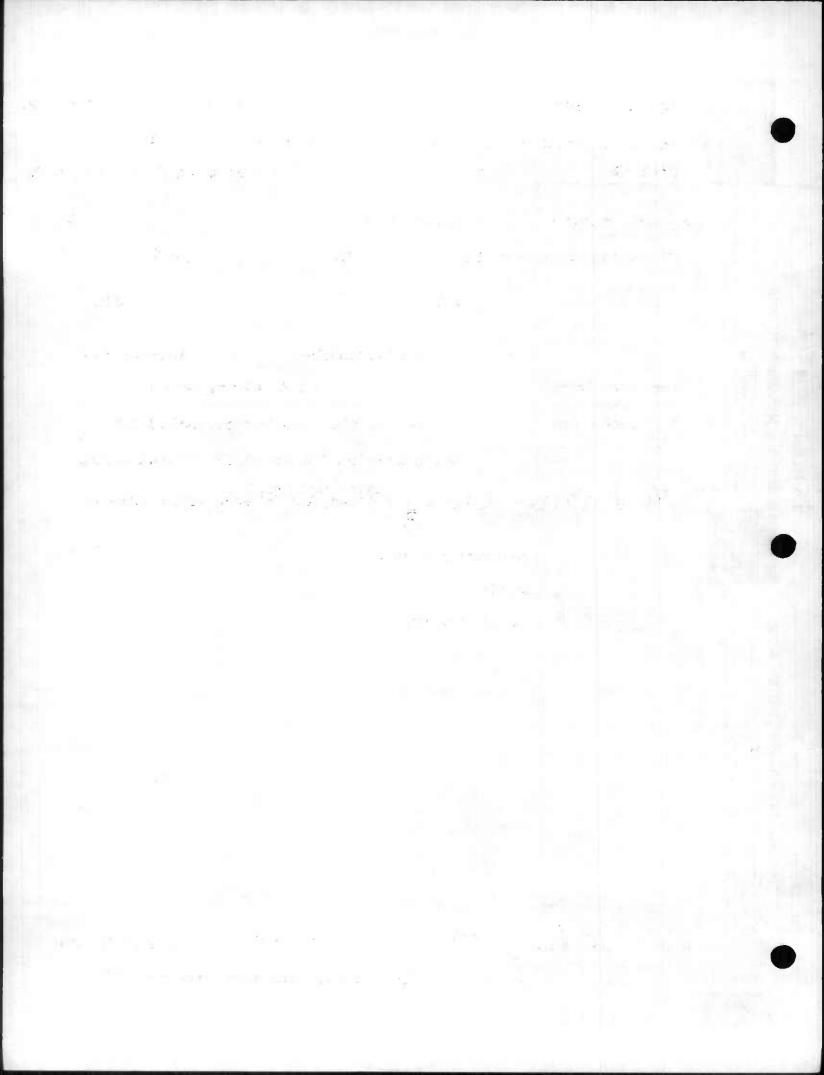


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** August Edward Smith 1:55 P.M. February 27, 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) Examiner Baltimore Rosedale Franklin Square Hospital Center If Undar 1 Yaar | If Undar 24 Hrs Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sex 8. Data of Birth (Month, Day, Year) **Funeral** Hours 1 M 2 □ F Months Days 212-03-3408 85 Yrs. October 28, 1912 Baltimore, Maryland Director Usual Rasidanca of Decadant the Maryland 10c. City, Town or Location 10d. Insida City Limits 10a. Stata 10b. County 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Exertings must be notified at 1 ☐ Yas 2 ☐ No Directo Maryland Baltimore Baltimore County 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 4408 Freestone Lane 21236 Apartment 102 USA Funeral death Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian. 12. Was Decedant Evar in U,S. Armad Forcas? 11. Marital Status Black, Whita, atc. 12 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural" or item 1 XXYas 2 □ No If Yas, Giva Year or Datas: WW Ⅱ 1 Navar Marriad 2 Married Maryland 21215-0020 1 ☐ Yas 2XNo Specify: Specify: þ 3 NWidowed 4 □ Divorced White Completed 16a. Decedant's Usuat Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Dacadant's Education (Specify only highast grada complated) Elementery/Secondery (0-12) Collega (1-4or 5+) 12 Operations Specialist Department of Army 18. Mother's Nama (First, Middla, Meidan Sumama) 17. Fathar's Nama (First, Middla, Last) Charles Adam Smith Elizabeth Barbara Rochlitz 19b. Meiling Address (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Pages 1 and 2 ment of Health a 8575 Castlemill Circle Baltimore, Maryland 21236 Brian E. Smith (Son) other t Baltimore, 20a. Mathod of Disposition 20b. Ptace of Disposition (Nama of camatary, cramatory or other placa) Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata injury or 4 ☐ Donation 5 ☐ Othar (Specify) Dulaney Valley Mem. Gdns. March 2,1998 Timonium, Maryland 21. Signatura of Funeral Sarvice Licensaa 22. Nama and Address of Facility Lassahn Funeral Home, Inc.
7401 Belair Road Baltimore, Maryland 21236-4625
23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast,
April 200 A Approximete Intarval Between Onsat and Daath **Physician** /Medical Immediate Causa (Final a Respiratory failure 1 hour disaasa or condition resulting in daath) Examiner Dua to (or es a consequence of) Examiner Sepsis burial-tran Saquantially list conditions, if any, laading to immediate cause. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in daeth) Last Dua to (or es a consaguanca of) ם Chronic Leukemia physician Box 68760 Physician/Medical 8 Due to (or as a consequence of) 8 957 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 à 1 ☐ Yes 2 No 3 Probably 4 Unknown bed bed b Records, p 24b. Wera eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed Deen has **page 2** 1 ☐ Yas 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Division of Vital Physician: 25. Wes case raferred to medical 26. Placa of Daath (Check only ona) Be Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 10 200 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Daath 1 Natural 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Attending 5 Panding For Attending after death. Director: Aft 1 Tyes 2 □ No invastigation 2 Accidant 6 Could not be datermined 28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 Homicida hours Reports 29a. Certifian 1 🔼 Certifying Phyaician: To the bast of my knowledga, death occurred at tha time, dete and placa, and due to the causa(s) and mannar as stated Medical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the tima, data and place, and dua to the cause(s) and manner stated. (Check only one) To the Within 2 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of cartille February 27, 1998 25+1 30. Neme and eddress of person who completed causa of daath (Itam 23e) (Type, Print) 9000 Franklin Square Dr. Baltimore, Maryland 21237 Dr. Stephen Selinger 2. Ragistrer's Signatura 31. Data filad (Month, Day, Yaar) State Mit Truiter - Gendalle

DHMH 16 Rev 6/95

Registrar

MAR 0 3 1998



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death February 28, 1998 Viola Eva Stricker 9:00am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 13 Glade Avenue Baltimore County Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) March 15, 1916 If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 F Months Days Yrs. Baltimore, Maryland 81 219-18-9656 Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. fnslde City Llmits 1 ☐ Yes 2 ☒ No Baltimore Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Glade Avenue 21236 LISA 11. Meritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Riack. Whife, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 277 Married 1 ☐ Yas 2 X No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade complated) Elemantary/Secondary (0-12) College (1-4or 5+) N/A Homemaker Housekeeping-Own Home 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Christian Johnson Florence A. Unknown 19a. fnformant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Baltimore, Maryland 21236 William E. Stricker (Husband) 13 Glade Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Locetion - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery March 3, 1998 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Lassahn Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting In death) emenua Due to (or es e consequence of): rt I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

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physician

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To the Hospital c within 24 hours el To the Funeral D completely filled is

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Completed

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Certification: To

Medical

Attending Physician: The law requires that the death certificate be executed

Box 68760.

of Vital Records, P.O.

Division

Physician

Examiner

Funeral

Director

r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at

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21215-0020

Baltimore, Maryland

/Medical

Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Causa (Disease or Injury that initieted events resulting in deeth) Last Physician/Medical

Part II.	Other eignificant	conditions contributing	to death but n	ot resulting in tha	underlying ceuse	given In Par

1 ☐ Yas 1 Tyas 2 No 25. Was cesa referred to madical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding Investigation 2 Abcident 1 Yes 2 No 6 Could not ba 3 Suicide 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Cartifiar (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua fo tha ceuse(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, date and place, and due to tha causa(s) and manner stated.

29b. Signature end)title of certifier

29d. Date signed (Month, Day, Yeer) 36437

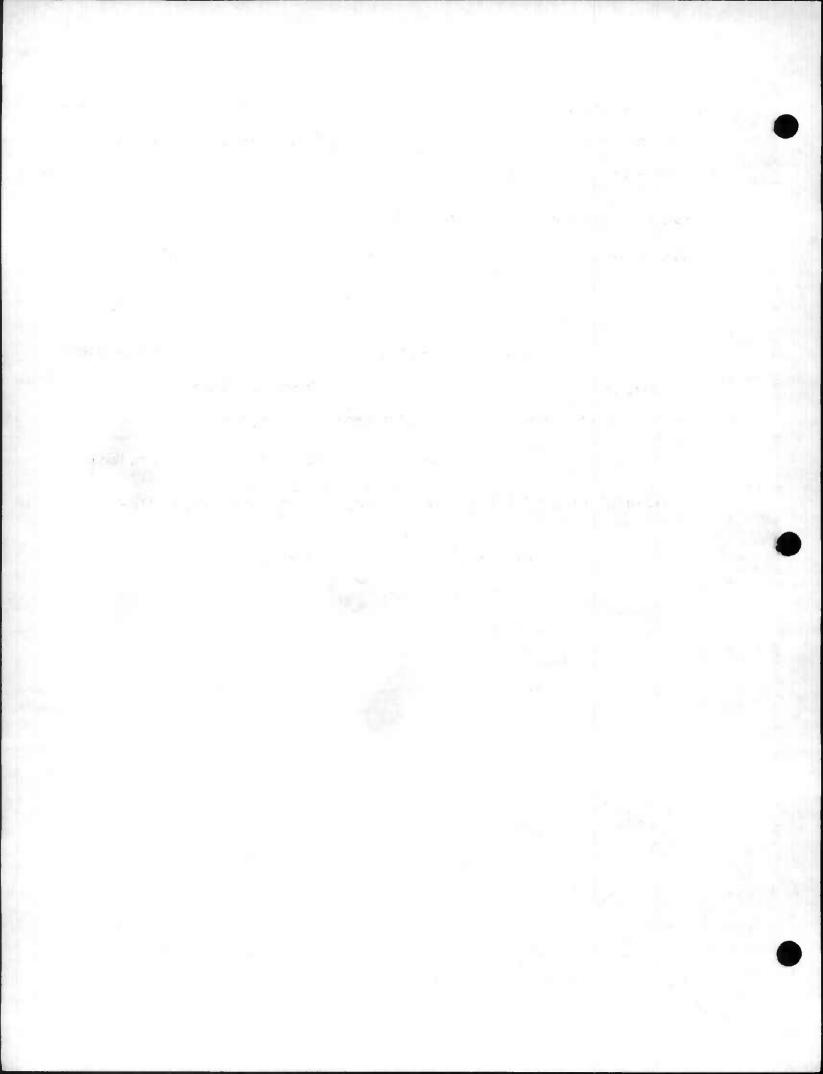
30. Name and addrass of parson who complated causa of daath (Itam 23a) (Type, Print)

35 E. PADONIA Rd 21093 31. Date filed (Month, Day, Year)

State Registrar

MAR 0 3 1998

32. Registrar's Signatura which Davidson - Andrew



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene SHEPHERD I tems: 23a part I, 27, 28a-f per MEO G-757 3/5/98 dh Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Dey Month Kathy Jean Shepherd FEBRUARY 13,1998 0010 A 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth WASHINGTON COUNTY HOSPITAL ER WASHINGTON Hagerstown If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Yeer) If Under 1 Year 7. Age (In yrs. lest birthdey) Birthpiece (State or Foreign Country) 1 □ M 2 🖸 F Months Deys Yrs. March 7, 1963 Maryland 10c. City, Town or Location Hagerstown Washington 10d. inside City Limits 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 1149 Beechwood Drive 21740 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American indien. Bleck, White, etc. 1 ☐ Yes 2 ₹ No tf Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilaga (1-4or 5+) Youth Services secretary 18. Mother's Name (First, Middla, Maidan Surname) 17. Fether's Neme (First, Middle, Last) Jean Winifred Dunham William Franklin Dunham 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. informent's Neme/Ralationship (Type, Print) 1149 Beechwood Drive Hagerstown, Maryland 21740 William F. Dunham 20b. Plece of Disposition (Nema of cemetery, cremetery or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 2/16/98 Hagerstown, Maryland Rest Haven Cemetery 22. Name end Address of Fecility 21. Signeture of Funerel Service Licensee Gerald N. Minnich 305 N. Potomac Street 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Mary Land 21740 shock, or heart failure. List only one cause on each line. intarvei Batween Onset and Deeth MULTIDRUG (MORPHINE, DEXTROMETHORPHAN PROMETHAZINE, Immediata Ceuse (Final disease or condition resulting in death) PAROXETINE) INTOXICATION Due to (or es e consequence of): Sequentielly list conditions, if eny, laading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequenca of):

Physician /Medical Examiner

Box 68760

Division of Vital Records, P.O.

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other

Department of important: If any injury or once. injury or

> Examiner and physician Physician/Medical 2 E S signed by p 2 Completed 984 **D8092** certificate Be 2 報 Certification:

Pert It. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was en autopsy performed?

24b. Ware autopsy findings eveileble prior to completion of cause of death?

1 Yas 2 □ No 26. Plece of Deeth (Check only one)

197Yes 2□ No

25. Was casa referred to medicel 1X Yes 2 No 27. Menner of Deeth

1 Naturel

2 Accident

3 Suicide

4 Homicide

Hospital: 1 ☐ inpatient 5 Pending investigation

6 CXCould not be determined

28e. Dete of injury (Month, Dey Year) found 2/12/98 | found 11:30 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of Injury

2 ER/Outpetient 3□ DOA

28c. Injury et Work? 1 ☐ Yes 2XXNo

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred unknown

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 1149 Beachwood Drive, Hagerstown, Maryland

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end manner stated. (Check only one) 29b. Signeture end title of cartifier

Wavid

31. Date filed (Month, Day, Year)

29c. License number

1 Certifying Physician: To tha best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and manner as stated.

OCME

29d. Dete signed (Month, Dey, Year)

FEBRUARY 14,1998

29a. Certifier

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

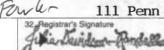
unknown

111 Penn Street, Baltimore, Maryland 21201

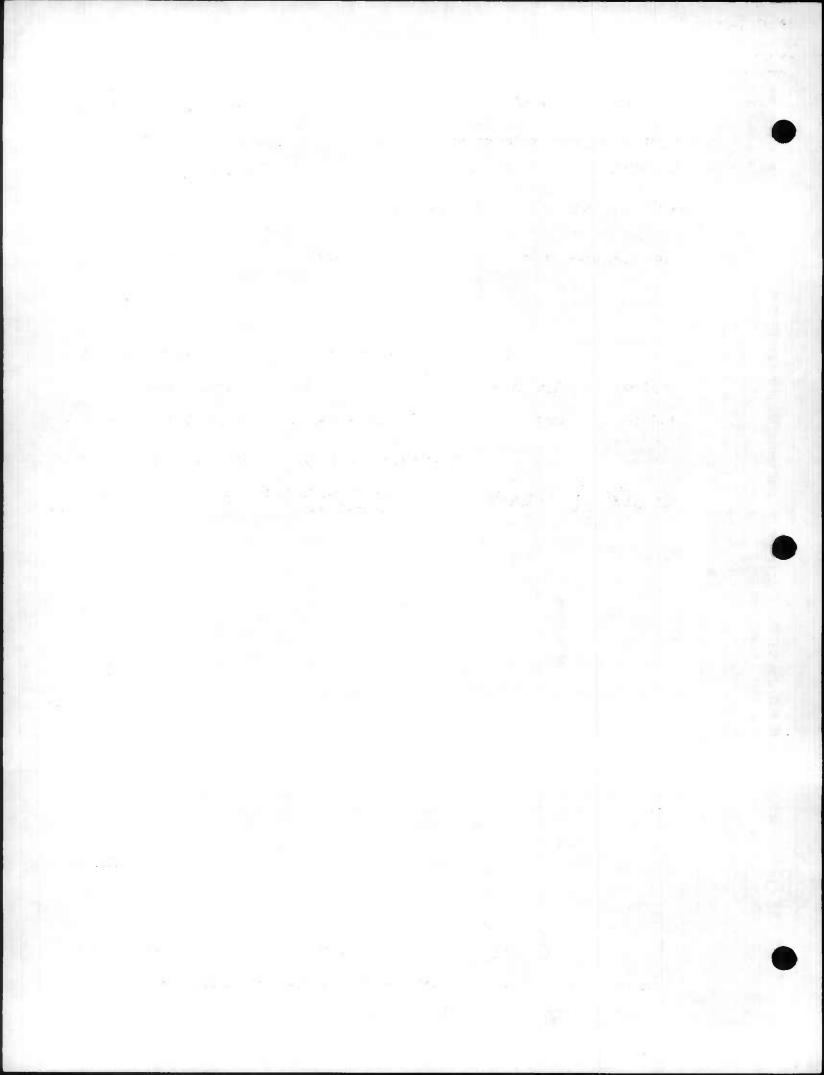
State Registrar

Medical

MAR 0 3 1998



To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1 Decedent's Name (First Middle Last) 1205 1998 **Physician** February 25 ELIZABETH HELEN TICHA /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not Institution, give street and number) 4c. County of Death Examiner Mariner Health of Bel Air Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 24, 1913 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days Hours Min Yrs. Maruland 84 **Director** 213-10-7440 Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City. Town or Location 10d, Inside City Limits 28a-f show 7 is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Modical Examiner must be notified as 1 ☐ Yes 2 No Maryland Forest Hill Directo Harford 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1800 Patula Court 21050 USA Funerai 72 hours efter deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: specity: White p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Homemaker Own Home Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f James Bishop Rosina Pfarr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) permit. Pages 1 end 2 st Department of Health and Important: If item 27 is rt any Injury or other traum Elizabeth Goldbeck (Daughter) 1800 Patula Court. Forest Hill, MD. 21050 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Entombment Bel Air Mem. Gardens 2/27/98 Bel Air. Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, 21. Signature of Funerel Servica Llogni 610 W. MacPhail Road, Bel Air, MD. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner attending physician end for use as the bunal-trensit that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Physician/Medical Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the isigned by the 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed peen completion of cause of death? certificate hes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as atated.
2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

30916WWarton bol

29d. Date signed (Month, Day, Year)

February 25, 1998

State Registrar

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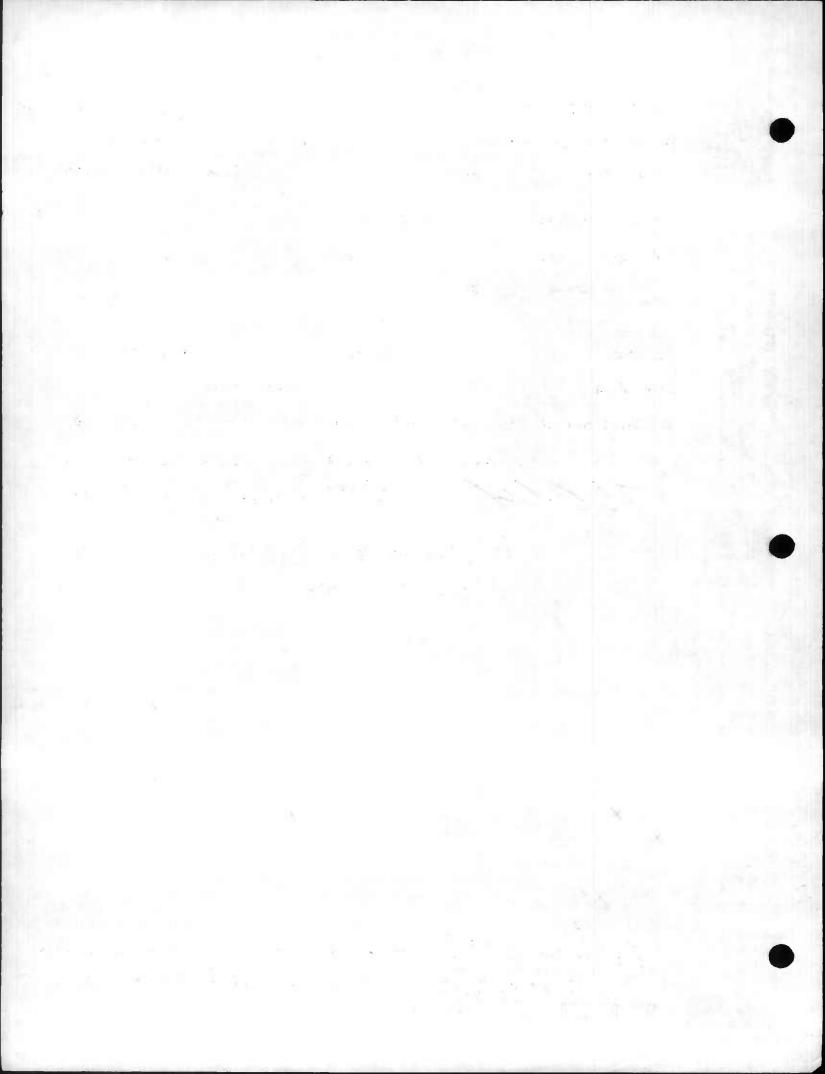
29a. Certifier (Check or one)

29b. Signetur

dress of person who completed cause of death (Item 23a) (Type, Print)

To the I within 2 To the P

Icha, Chizabeth



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 4c per M.D. G-757 3/3/98 reb 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Year I nes (IncolTice 704A 98 28 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Johns Hopkins Bayview CENTES day) If Under 1 Year Baltimore medical 5. Sociel Security Number If Under 24 Hrs. Birthplece (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Days Hours 220-20-6118 1 □ M 2 F 71 12-08-1926 Maryland Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 3811 Mt.Pleasant Avenue 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Baltimore City College (1-4or 5+) Secretary 12th Hospital 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Theresa Bearzatti Anthony Castagnera 19a. Informent's Name/Reletionship (Type, Print) Daughter | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 33 Seaford Avenue, Baltimore, Maryland 21221 Dale Quisgard 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 3/3/98 Baltimore, Maryland Oaklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Joseph N. Zannino Jr. Funeral Hm Jarea 263 S. Conkling St. Baltimore, Maryland 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Onset end Death Immediate Cause (Final cerebrovascular accident 5 days disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hyrertons10n 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

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To the Hospital o within 24 hours ell To the Funeral Di completely filled in

The law requires that the death certificete be executed

Box 68760,

P.O.

Records,

Division of Vital Attending Physician: **Physician**

/Medical

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Director

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinating the motified at

I Hygiene.

Pages 1 and 2 should be fight of Health and Mental Int: if Item 27 is marked of

other t

Injury or Department of Important: if any Injury or

death with the Maryland

filed within 72 hours after

Maryland 21215-0020

Baltimore,

Examiner

buriel-tran Physician/Medical the 8 þ Completed funerel director, Be of the offer death.

Director: Aft

Certification: To 27. Manner of Deeth

Medical

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25. Was cese referred to medical 1 ☐ Yes 2 No

29e. Certifier

5 Pending Investigation 1 Natural 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Dey Year)

1 1 Inpatient 2 ☐ ER/Outpetlent

28h Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3□ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

26. Place of Deeth (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) and menner es steted.

2 Medicat Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29b. Signature and title of certifier 29c. License number

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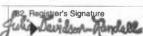
29d. Date signed (Month, Dey, Yeer)

30. Name and address of person who completed cause of death (ttem 23e) (Type, Print) John Tenbrook mo 4940 Bastern Ave. Baltimore MD 21224

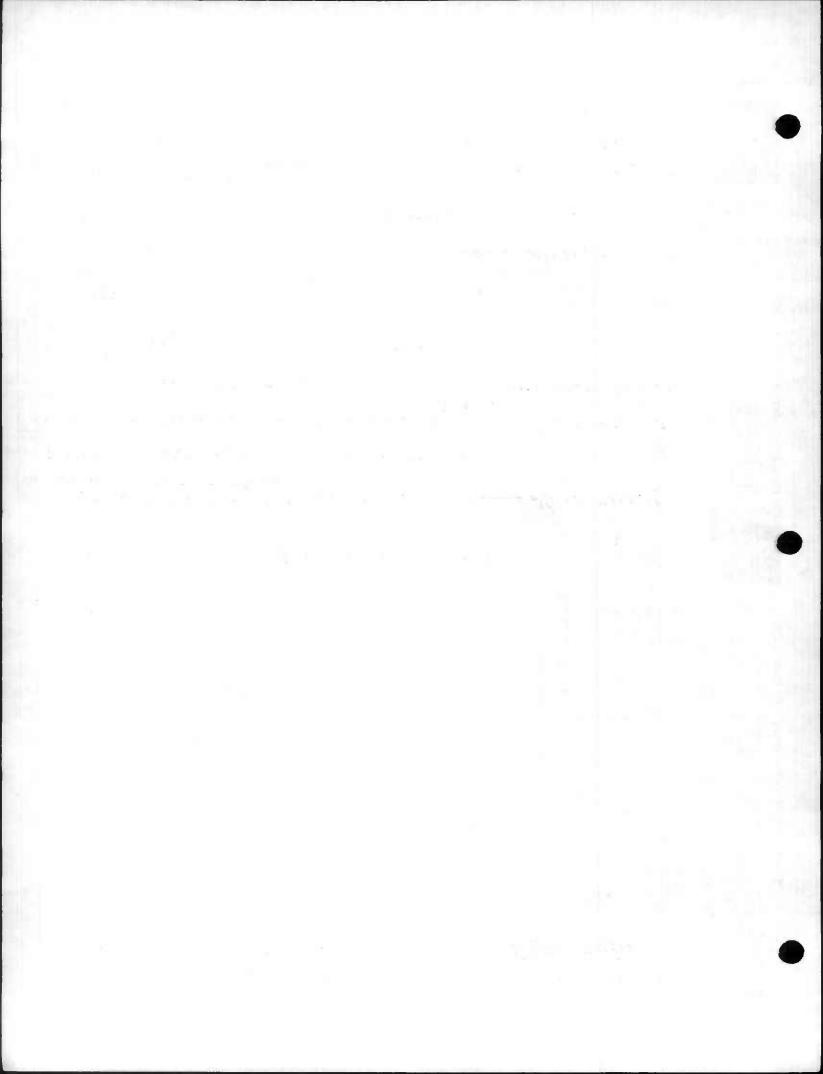
Hospital:

31. Dete filed (Month, Day, Year)

MAR 0 3 1998



Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death 40 A. OW lek Feb 26 98 Facility Nama (If not institution, giva street and number) 4b, City, Town, or Location of Daath 4c. County of Death Baltimore NA 7. Aga (In yrs. last birthday) COUR 010 If Undar 1 Yaar Months Days 6. Sax. If Undar 24 Hrs. 5. Social Sacurity Number Birthplaca (Stata or Foraign Country) Min. Hours 219-64-9399 Yrs Usual Rasidance of Decedant 10a, Stata 10b. County City, Town or Location 10d. Inside City Limits AM Mo 1 Yes 2 No saltimore 10a. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 33 21201 DSA 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritai Status 14. Race - American Indian. Black, Whita, atc. Yas 2 No Yas, Giva 1 Navar Married 2 Married 1 Yas 2 No Specify: 3 Widowad 4 Divorcad ac Yaar or Datas: 15. Decedent's Education (Specify only highast grada complated) 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry College (1-4or 5+) Elamentary/Secondary (0-12) unknown 1+1 aborer 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumame) Wooden ONN 00 EVELYN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Numbar & Rural Roule Number, City or Town, Stata, Zip Code) Dolfield iowler. 23t2KG 3805 Dorothy rat-10. 20a. Mathod of Disposition 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata camatary, cramatory or other placal 1 Burial 2 Cramation 3 Removal from State Memorial 3 -4-95 Randalls town, my Parte 4 ☐ Donation 5 ☐ Othar (Specify) Home West INC 21. Signature of Funaral Sarvice Licansaa 22 Nama and Address of Facility arris 4300 Wabash 23a. Pan1. Entar the chaasa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death Immadiata Cause (Final diseasa or condition resulting in death) Massive Ascil Due to (or a 0 Saquantially list conditions, if any, laading to Immediata causa. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as consequanca of): /u Dua to (or as a consequence of); Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 2 No 1 Yes 3 Probably 4 Unknown 24b. Ware autopsy findings 24a. Was an autopsy available prior to completion of cause of death? performed? 1 Yas 2 NO 1 ☐ Yas 2 No 25. Was casa referred to medical axaminer? 26. Place of Death (Check only one) 3 No Hospital: Othar: 4 Nursing Home 1 Inpatiant 1 Yas 2 ER/Outpatient 3□ DOA 5 ☐ Rasidance 8 ☐ Othar (Specify) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 2 Accidant 5 Panding invastigation

6876 Ba The law requires that the death certificate 98 Box for use P.O. page 2 should be deteched à Division of Vital Records, certificate hes Attanding Physician: funeral director, this After ie Hospital or Attandin n 24 hours efter death.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

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permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryla. Department of Heelth and Mantel Hydiens. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madrial Examinal must be notified an once.

Physician

/Medical

Examiner

Physician/Medical Examiner

by

Completed

Be

Certification: To

Medical

filled in by

completely

within 2

3 Sulcida

4 Homicida

29b. Signatura and titla of confile

Baltimore, Maryland 21215-0020

the Maryland

1 Yas 2 No 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifian (Check only one)

6 Could not be daterminad

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

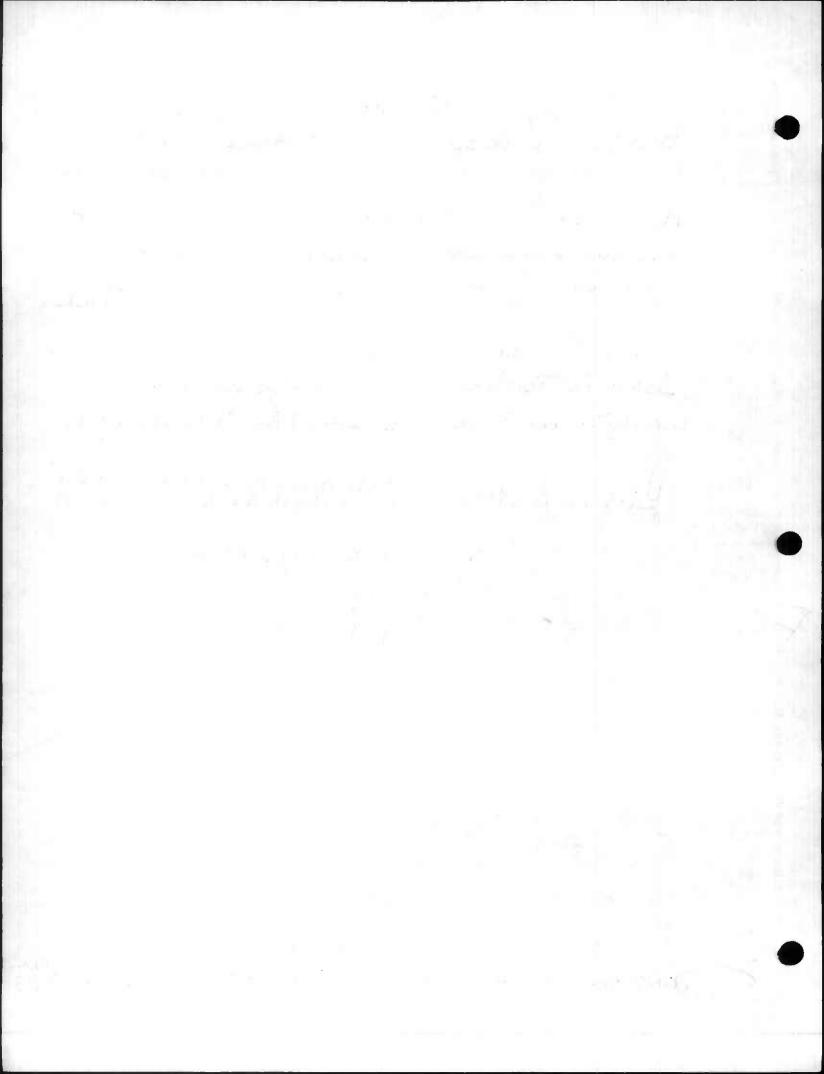
29c. Licansa numbar 29d. Data signed (Month, Day, Year)

23a) (Type, Print) 30. Nama and address of parson who complated causa ot death (Item

State Registrar

32 Ragistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 566 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month Day Yaar **Physician** February 27, 1998 5:40 PM CHAO HWA TUNG /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Multi Medical Center Genesis Elder Care Baltimore Towson 7. Aga (In yrs. lest birthday) If Under 1 Yaar If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthpieca (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months 1 M 2X F Hours Director 95 Nov. 17, 1902 218-54-6857 China Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. Stata 1 ☐ Yes 2 No Director Md. Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 601 Stacy Ct. 21286 USA Funerai 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black White etc. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by Chinese 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) Professor Physics 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Unknown Unknown Kwan San 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 601 Stacy Ct. Towson, Md. 21286 Mrs. Rebecca Hsieh/daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3/2/98 Towson, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Deeth **Physician** Cardiovando dissen Immediate Ceuse (Final disaese or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, If eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): The lew requires that the death certificent 23b. Did tobacco usa contributa to the ceusa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. portossis 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to been sig 24e. Wes en eutopsy performed? Completed completion of cause of death? page 2 s 2 No 1 ☐ Yes 2 ☐ No After this certificate Hospital or Attending Physician: Be 25. Was cese referred to medical 26. Place of Death (Check only one) examiner? Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 1 Naturel 2 Accident 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation deeth. 1 Yas 2 No eral Director: / 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours edicai 29e. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) and menner stated. pletely (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/2/98 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

98 N. Broadway # 410

M.D.

Julia Jan don Sipper 10

Chi-Shiang Chen

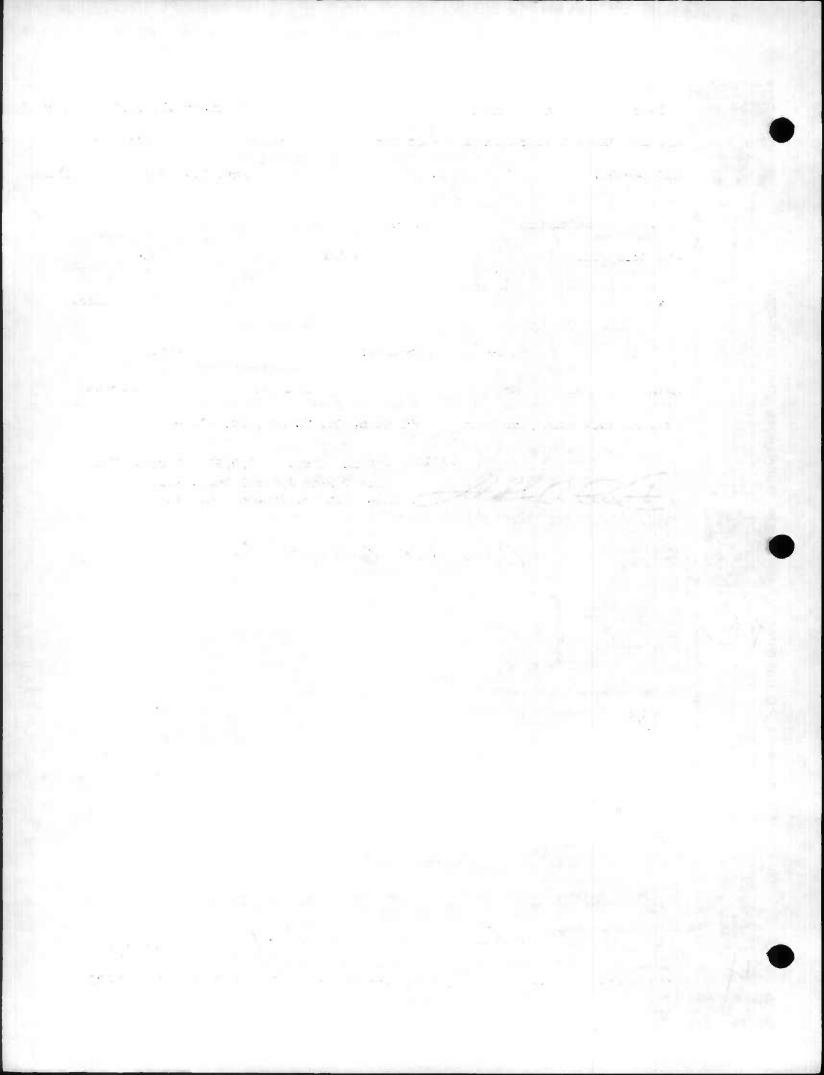
31. Dete filed (Month, Day, Year)

MAR 0 3 1998

Balto, MD

21231

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3 Time of Death Day **Physician** : FFord Thomas March 01:35 am 2nd 1998 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deall **Examiner** S Baltimore danes Hospital # Under 1 Year | If Under 24 Hrs. | 8. Deta of Birth Months | Days | Hours | Min. | Min. | Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpleca (Steta or Foreign
 Country) 216-30-732 Usuel Residence of Decadent 1 M 2 F 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland 1⊠Yes 2□No Director more 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country Apt. 12. Wes Decedent Ever in U.S. Armed Forces?

1 — Yas 2 No II Yes, Give Year or Delea 21 104 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 11 Marital Status 14. Raca - American Indian Black, White, etc. 1 Never Married 2 ☐ Merried 1□ Yes 2 No Specify py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be noma 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, 19e. Informant's Neme/Reletionship (Type, Print) (cousin) 20b. Placa of Disposition (Name of cemetery, crematory or other) town, 20e. Method of Disposition Dete/ 20c. Location - City or Town, State 1 ⊠Buriai 2 □ Cremetion 3 Ramovai from State Viemoria 4 ☐ Donetion 5 ☐ Other (Specify) Ta 21. Signature of Funeral Servica Licensee 22. Name and Address of Eacility
JOSEPH L. KU
2222 W. Nort Home unera 23a. Pen¹ Enter the dismise, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, show or heart feiture. List only one cause on each line. Balto Approximete Interval Between Onset end Death Immediate Cause (Finai disaese or condition resulting in death) Examiner a Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in daath) Lest Due to (or es e consequenca of): ean 0 Physician/Medicai Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 Unknown 24b. Were eutopsy findings aveilebla prior to Completed 24e. Wes en eutopsy completion of cause of deeth? 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 28. Piece of Deeth (Check only one) examinar? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Rasidance 8 Other (Specify) 20 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? Medical Certification: 1 Naturei

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Funeral

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permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyglic Important: If Item 27 is marked other I any Injury or other traumatic event.

Physician /Medical

Examiner

the Medical Examiner nant be notified at

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Baltimore, Maryland 21215-0020

5 Panding investigation 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29e. Certifier

🗷 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated.

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29b. Signeture end title of certifiar

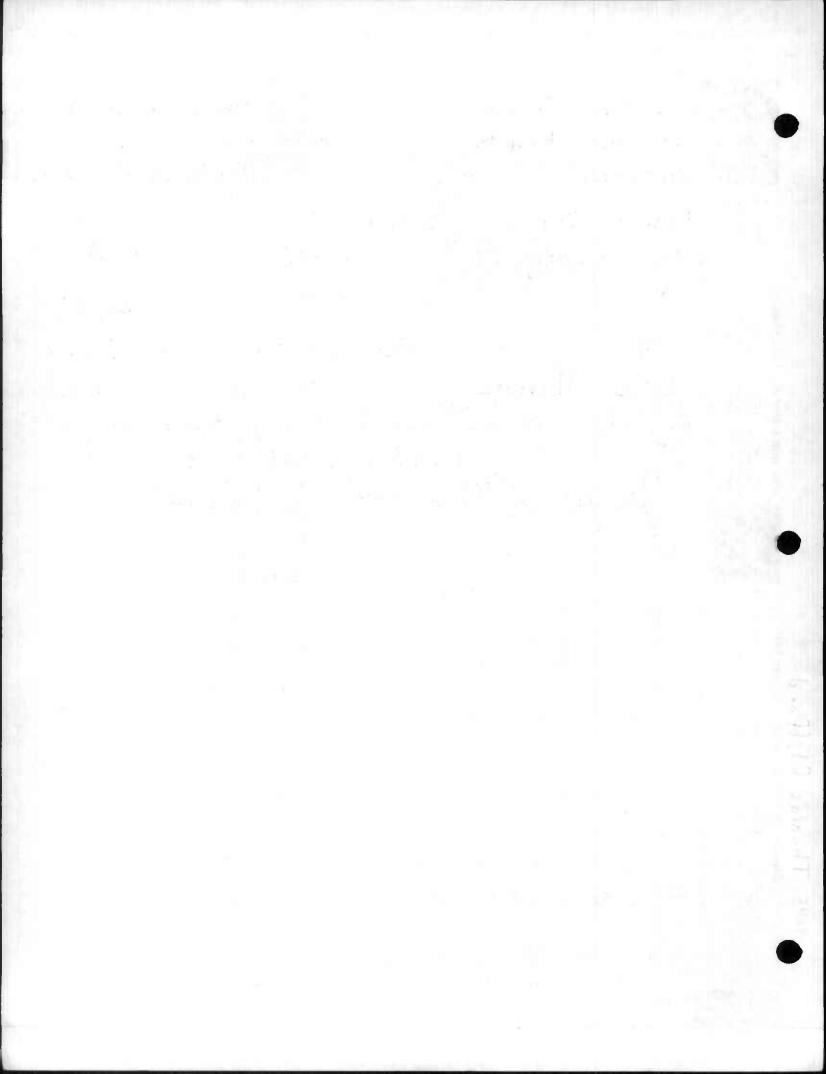
29c. License number

29d. Date signed (Month, Dey, Year) March 2nd

nd eddress of person who completed ceuse of death (Item 23e) (Type, Print)

MOHAMMAD EEM SAL MN 32 Agoistrant Signature Randon 31. Date filed (Month, Dey, Year) MAR 0 3 1998

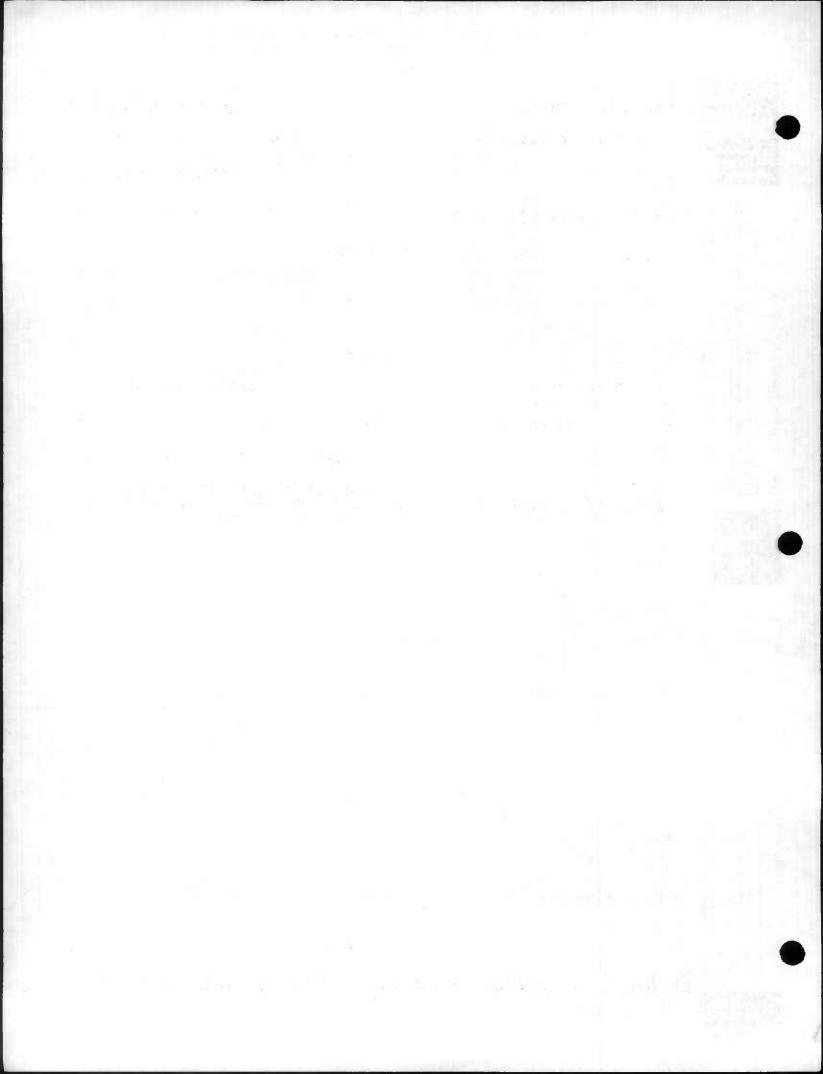
State Registrar



State of Maryland / Department of Health and Mental Hygiene 98

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	144 140	_	1. Decedent's Neme (First, Middla, Las.	()				2. Date of Dee		3. Time of Deeth
	Physic /Medi		Mary Ellen Tu	rner				FEBRUA	ARY 20	1998 1425
	Exami		4a. Fecility Nema (If not institution, give				4b. City, Town, or		,	
			Sacred Heart	Hospital			Cumberl		Alleg	gany
	Funeral Director		230-02-1410	7. Aga (in yrs.	last birthday) Yrs.	Months Days		(Month, De)	Year) 1906	9. Birthplece (State or Foreign Country) Rough Run, WV
	and *-		Usuel Rasidence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	he Maryi 28a-f sho	Director		-Mineral Ke						1⊠Yes 2□No
	23a or 3		10e. Street and Number 500 Carskadon	Lane Apt.	102	10f. Zip Code 26726	5		10g. Citizen of V US	What Country?
21215-0020	72 hours after death with the Maryland "natural", or items 23a or 28a-f show added Exacilizer frust be notified at	by Funeral	11. Meritel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Dacedent Ever in U, Armed Forces? 1 ☐ Yas 2 ∑ No If Yes, Give Yeer or Detes:		Wes Decedent of If Yes, specify Cu 1 ☐ Yas ②☐Wo	Hispanic Orlgin? (S ben, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Blac	e-Amarican Indien, ck, White, etc. "White
5	72 h	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16e. Dece	dent's Usuel Occu	upetion B during most of wo	rkina		usiness/Industry
121		du	Elementary/Secondery (0-12)	College (1-4or 5+)			e during most of wo		10 / 0	
7	il Hygiena. other than	8	8 17. Father's Name (First, Middle, Last)		нот	emaker	40 Mathada Ma	me (First, Middle,	n/a	
an	S da S	Be	John Mongold,	SR						
Maryland	should be ind Mental marked o	2	19a. Informent's Neme/Reletionship (T			nia Rittenour ral Route Number, City or Town, State, Zip Code)				
	d 2		Melvin Ralph				225 A,			
altimore,	permit. Pages 1 end 2 should Department of Health and Mer Important: If Itam 27 la marke any Injury or other traumatic QDCs.		20a. Method of Disposition 1 Burial 2 Cremetion 3 F	Removel from Stete	emetery, crea	osition (Name of metory or other pl		Date 2 / 2 5		City or Town, State field, WV
	artme ortan injur		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licans		2	2. Neme end Adde	rass of Fecility			
B	Depar Impor any ir		Jamela D. E	emare	2 1	lmore-1 7 WIncl	Chambers hester A	ive., Mg.	ld, WV	26836
			23e. Pert1. Entar the disease, or comp shock, or heert feilure. List only o	lications that caused the deeth ne cause on each line.	n. Do not en	ter tha moda of dy	ring, such as cardia	c or respiretory en	rest,	Approximate Intervel Between Onset and Deeth
	Physician /Medical		Immediete Ceuse (Finel	*						
	Examiner		diseese or condition resulting in deeth)	e. CHRONIC			IVE LUM	JG DIS	EASC	TEN YEARS
L		ē		b EMAH	r es e conse					TEN YEARS
	cuted	Examiner	Sequentially list conditions	0.	res a conse	1				///// 7
60,	be exec icien er burial-t		Sequentially list conditions, if eny, leading to Immadiate cause. Enter Underlying Ceuse (Disease or Injury	c						
ox 68760,	eath certificate be executed ettending physicien end for use as the burial-transit	/Medical	thet Initiated events resulting in deeth) Lest							
Bo.	es that the death certigned by the ettendin be detached for use	Physician	Pert If. Other significent conditions con	otributing to death but not rea	23h Did to	COL PILANE				
P.O.	by the	hys				23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknow.				
S, F	s tha	ру Р	CUNG ESTIVE H	EAR) FAILURS	G			, ,	24.10	
Division of Vital Records,	requir seen s hould	Completed	DEMENTIA	PERIPHER	Ar V.	ASCULAR	- DISFASE	24e. Wes e perfor	en eutopsy med?	24b. Were eutopsy findings eveileble prior to completion of causa of deeth?
æ	The law ata has b	шо						1 U Y	es 2 No	1 ☐ Yes 2 ☐ No
ta		Bec	25. Wes case referred to medical				26. Plece of De	eth (Check only or		
>	5 00	To	exeminer? 1 Yes 2 No	Hospitel: 1) Inpatient 2	ER/Outpetier	nt 3 DOA O	ther: 4 Nursing I	lome 5 ☐ Resid	ence 8 Oth	er (Specify)
0			27. Manner of Death 1 S Naturel 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. fnju	ury et ork?	28d. Describe h	ow Injury occur	red
sio	death. death. ctor: A y the fu	cati	2 Accident Investigation 3 Suicida 6 Could not be			M 1	Yes 2 No			
\leq	or Attendations after death	Certification:	4 Homicide determined	28e. Placa of Injury - At ho building, etc. (Specify		reat, factory, office		28f. Location (S City or Tow	treet and Numb n, Stete)	er or Rural Routa Number,
	pital ours a eral [29e. Certifier 150 Certifying Phy.	eleten. To the best of multiple		h account of the t	in determination			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical		raician: To the best of my know iner: On the besis of examinat end mannar stated.	tion end/or in	vestigation, in my	opinion, death occu	urred at tha time, o	date end plece,	end due to the cause(s)
	withir To th comp	Me	29b. Signetura and title of certifier			29c. Licer	nsa number	2	29d. Data signe	d (Month, Day, Year)
	-		Harin			D 2	6907		FEB 9	0,1998
			30. Name end eddress of person who co	ompleted cause of death (Item	23е) (Дуре,			1 1	0	1.10
			DR HARVIE S. !	5/d hu-7/2	2 Bis	KOP Wa	USK KOAO	-cum lee	Rland	Md. 21502
	Sta		31. Dete filed (Mohth, Day, Year) MAR 0 3 1998	32. Registrer's Signal	ture					
	Registr	ar	17171 U U 1330	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -						

DHMH 16 Rev 6/95



98-1110-005 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene RENATO PETER VAN DEN Certificate of Death ELZEN Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Month Dey **Physician** Renato P. van den Elzen FEBRUARY 27,1998 22:30 PM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner ROUTE 40 AND STEVENSON LANE Baltimore County BALTIMORE 8. Dete of Birth (Month, Day, Year)
December 18,1958 | Netherlands 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 □ F Months Døys Hours Yrs 39 156-56-0573 Director Usuel Residence of Decedent the Meryland 10d. Inside City Limits 10e Stete 10b Counts 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Baltimore County Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 3920 Link Avenue Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Detes: 14. Race - American Indien. 11. Meritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Bleck, White, etc. filed within 72 hours efter 1 Never Merried 2 Merried Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Hygiene. College (1-4or 5+) Manager Maintenance Dundalk Marine Terminal 18 Mothar's Neme (First Middle Maiden Sumema) 17. Fether's Neme (First, Middle, Last) Peges 1 and 2 should be frent of Health and Mental Frit: If Item 27 is marked of Maria Sophia Rotteveel Mario van den Elzen 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Melanie A. van den Elzen (wife) 3920 Link Avenue Baltimore, Maryland 21236 other altimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1XXBurlet 2 Cremetion 3 Removel from State ò permit. Pege Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) St. Joseph's Church Cem. March 3, 1998 Baltimore, Maryland 22. Name end Address of Fecility 21. Signeture of Funeral Service Licansee Lassahn Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or raspiratory errest,

Applications that caused the deeth. Do not enter the mode of dying, such as cerdiac or raspiratory errest,

Applications that caused the deeth. Do not enter the mode of dying, such as cerdiac or raspiratory errest, Approximate Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) uries Examiner Examiner certificate be asscuted physician end s the burial-trens Sequentially list conditions, if eny, leading to immediata cause. Entar Undarlying Ceusa (Disease or injury that Initiated events resulting in deeth) Lest Due to (or as a consequance of): Box 68760 Physician/Medicai Due to (or es e consequence of) 88 Pert II. Other algniffcant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably MUnknown 2 signed I Records, þ 24b. Wara autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed peeu performed? Wayes 20 No 1 Yes 2 No Division of Vital lumeral director Be 25. Was cese raferred to medical 26. Piece of Deeth (Check only one) examiner; 1∆ Yes 2 No Other: 4 Nursing Home 5 Residence October (Specify) SCENE Hospital: Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Ahor Injury 1 Netural 5 Panding motoruchide collision death. 1 Yes 2 11€No 2. Accident 3 ☐ Suicide Investigetion 21370 2127/98 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) Rate 49.85 (2005). Lance 28e. Place of Injury - At home, farm, stree building, etc. (Specify) et, fectory, office mains after A 4 Homicide Street Baltinarre Partie and 11d Co. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner stated. edicai 29a. Cartifian 29d. Dete signed (Month, Dey, Year) 29c. License number

State Registrar

Chuteus Venno J. Registrar's Signeture 31. Date filed (Month, Dey, Yeer) MAR 0 3 1998

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

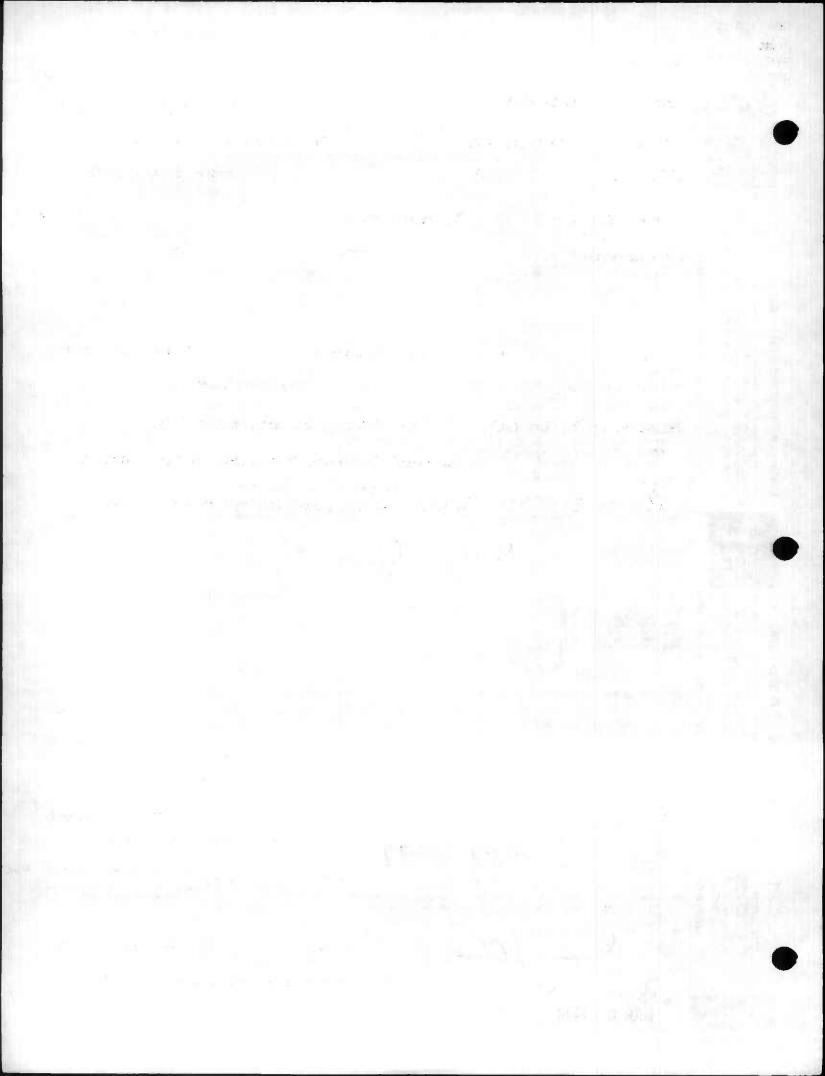
29b. Signature end title of certifier

win Davidson-Randell

OCME

111 Penn Street, Baltimore, Maryland 21201

FEBRUARY 28, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death FEBRUARY 25 1998 1650 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMOVE Hospital Age (In yrl. lest birthday) Mem LNION Hours Min. 8. Date of Birth Worth, Dey, 5. Social Security Number Birthplaca (Steta or Foreign Country) 1 M 25€ Months Days 888-03-266 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2095 45A 05e 12. Was Dacedant Ever in U,S. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Armed Forces? 1 Yes 2 1 Never Married 2 Marriad 1□ Yes 21 No Specify: Jack 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Spacify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer UNDI nk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Illie Mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Nymber or Rural Route Number, City or ATTIMONE, MD. 21229 20b. Placa of Disposition (Name of cemetery, cremetory or other plece) Buriai 2 Cremation 3 Removal from State Zion 4 □ Donation 5 □ Other (Specify) bonsdowne, MD 22. Name and Address of Facility

Physician /Medical

of Health and Mental Hyger I I Itam 27 Is marked other or other traumatic event,

Physician

/Medical

Examiner

Funeral

Director

r than "netural", or leams 23s or 28s-f show the Medical Examiner must be notified at

and 2 should be filed within 72 hours after

Pages 1

Sattimore, Maryland

Funeral Director

Examiner

Physician/Medical p Completed Be

Medical Certification: To

Completed by Be Roosevelt 20a. Method of Disposition 21. Signature of Funeral Service Licenses Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting In death) Last

23a. Fart1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACIDOSIS

DISEASE STAGE RENAL HYPERTENSION

BALTIMEN IND. 21217

Approximate Interval Between Onset end Death

IHOUR

art II. Other significant conditions con	23b. Did tobacco use co 1 ☐ Yes 2 No	23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknow				
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?	
5. Was case referred to medical			26. Place of De	ath (Check only one)		
examiner?	lospital: 1 Inpatient 2	ER/Outpatient 3□ D	OA Other: 4 Nursing F	fome 5 Residence 6 □Oth	nar (Specify)	
7. Manner of Death 1 ANatural 5 Pending 2 Accident Invastigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how Injury occur	red	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Placa of Injury - At h building, etc. (Special	ome, farm, street, factor fy)	y, office	28f. Location (Street and Numb City or Town, State)	per or Rural Route Number,	
9a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place n, in my opinion, death occu	a, and due to the cause(s) and ma urred at the time, date and place,	anner as stated. and due to the cause(s)	

29b. Signature and title of certifiar

Epstein

29c. License number

29d. Date signed (Month, Dey, Year) AT 2438946M13 FEBRUARY251998

201 E. University Pkay

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VERONICA 31. Date filed (Month, Day, Year)

32 Registrar'a Signature

State Registrar

La Davidson

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Day 24 1998 TOBRUARY **Physician** FRANCES WEINTRAUB 150 AM /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner THE TIMBIZE SINAL HOSPITAL OF BALTIMORE 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (in yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Months Deys Hours 1□ M 2₩ F VIRGINIA 214-20-5844 71 Yrs. Director Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral', or items 23a or 28a-f show Director 1 ☐ Yes 2 No BALTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4 TROTTERS CT., APT. 103 21208 USA by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Marital Status Peges 1 end 2 should be filed within 72 hours after in ant of Health end Mentel Hygiena. Int: If Itam 27 Is marked other than "natural", or ite 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Yeer or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorcad WHITE Completed the Medical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) FASHION COPYWRITER **FASHION** 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be KESSLER CHARLES LILLIAN **MEYERS** 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRVIN WEINTRAUB (HUS.) 4 TROTTERS CT., APT. 103 BALTO., MD if Itam 27 20e. Method of Disposition 20b. Pleca of Disposition (Name of cometery, crematory or other placa) 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from Stete Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) PETACH TIKVAH CONG. 2/27/98 ROSEDALE, MD 21. Signature of Funerel Service Licansee 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. Rat1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) . END STAGE BREAST CANCER WITH METASTASIS Z YCARS Examiner Due to (or es e consequenca of): Examiner The law requires that the death certificete be executed burial-transit Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. by Physician/Medical the Due to (or es e consequença of) P.O. Pert II. Other eignificant conditions contributing to death but not resulting In the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown CIRONARY ATZTERY DISEASE Records, 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? HIPERTENSION 2000 1 Yes 2 No cartificate 1 ☐ Yes Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 Yes 2 No 1 Nnpatient 2 ER/Outpetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA this in by the funeral 27. Menner of Deeth 28e. Dete of injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending investigation 1 Natural 24 hours after deeth. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, and due to the ceuse(s) and menner as steted.

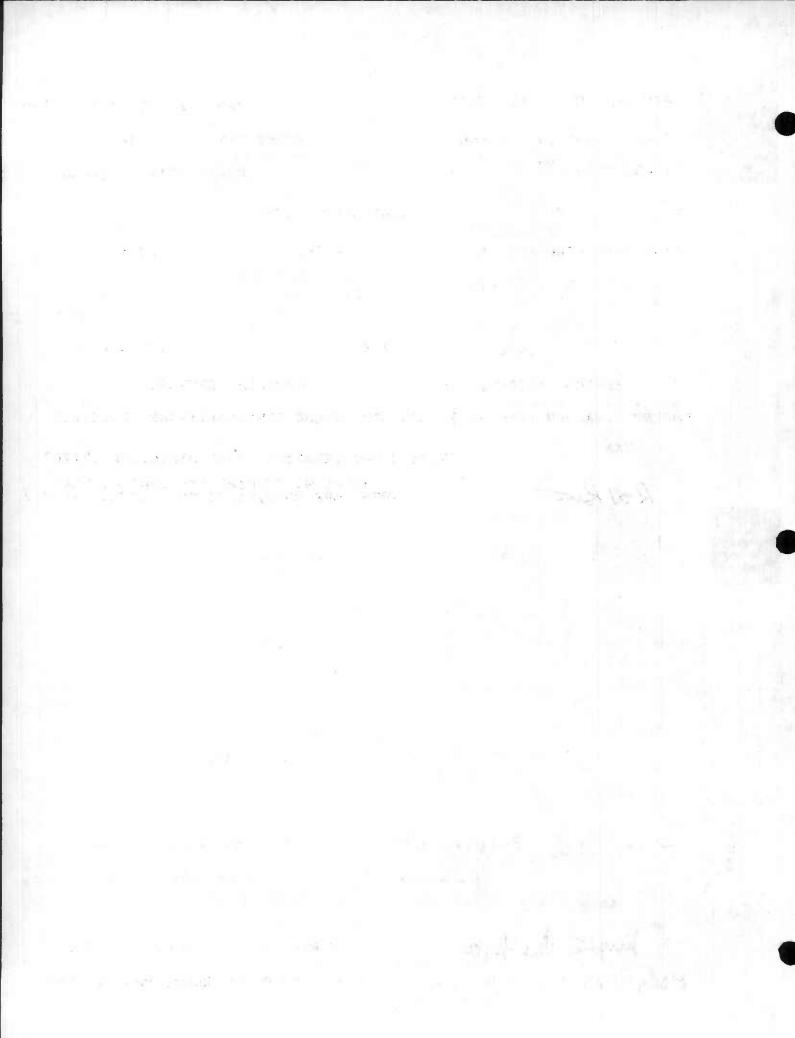
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) and manner steted. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certile 29c. License number AS2402321-JH9519 FCBKUARY 26 1998 2401 WEST BEINGDERE ANENUE 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) GUNIFOR HALPERN MD SINAI HOSPIFAL OF BALTIMORE BALTIMURE MARYLAND 21215 31. Dete filed (Month, Day, Year) 32. Registrer's Signature Fina Davidson Randoll State MAR 0 3 1998 Registrar

All Property of the party

State of Maryland / Department of Health and Mental Hygiene

			Decedent's Name (Fig. 1)	rst, Middle, L	X 2			Certificate	of Death	2. Dete of De	Reg. No.	8 00	5572 Time of Death	
	Physic /Medi		RICHARD	CAM	PBELL WA	AGNEI	3			FEBRU	ARY 21	,1998	7:12AM	
	Exami		4a. Fecility Name (If not	10			31		4b. City, Town, or Location of Death 4c. County of Death					
L			4307 FI 5. Social Security Number	RANKF		NUE je (In yrs. la	et hirth	(av) If Under 1	BALT1 Tear If Under 24 Hrs			N/A	10: -	
	_c Funeral Director		213-30-78 Usuel Residence of Dec	339	XXM 2□F	63	Yr	Months D	eys Hours Min.	(Month, Da	y, Year) -1934	9. Birthplace Country) MARY	(State or Foreign	
	nylano ihow			. County		10c. Cily		r Location					Inside City Limits	
	h the Meryland r 28a-f show	Director	MD. N/A BALTIMORE CITY									Х	Yes 2□No	
	ath with t 23a or 2	ral Dir	10e. Street end Number 4307 FRANKFORD AVENUE 10f. Zip Code 21206								10g. Citizen of U . S			
21215-0020	72 hours after death with the Meryland "natural", or items 23s or 28s-f show edical Examiner must be notified at	by Funeral	11. Maritel Status 1 Never Married 3 Widowed XXX		12. Wes Decedent Armed Forces? 1 ☐ Yes XXII If Yes, Give Year or Dates:		5.	13. Was Decedent If Yes, specify 1 Yes	of Hispanlc Orlgin? (S Cuban, Mexicen, Puert No Specify:	pecify Yes or No o Rican, etc.)	14. Rad Bla Specif	ce - Americen I ck, While, etc. y: WHI		
2	natur deal	etec		Decedent's E	ducetion ade completed)				ccupation one during most of wor	king	16b. Kind of B	usiness/Indust	у	
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b	othe	BeC	17. Fether's Neme (First,						18. Mother's Ner	ne (First, Middle,	Meiden Sumer	ne)		
<u>Xaa</u>	should be nd Mental marked c	To	HUGH EDV	VARD	WAGNER,	SR	•		REBEC	CA CA	MPBELI	,		
-	nd 2 alth a 27 is r tra		19a. Informent's Name/F			ER)			reet end Number or Ru Y RUN LAN					
Baltimore,	ant o ht: If I		20e. Method of Disposition 1 Burlal XX Cre 4 Donetion 5	malion 3	Removal from State	rom State 20b. Plece of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY						City or Town,		
Rait	permit. Pe Departmen Important: any Injury once.		21. Signature of Funeral	Service Lice	nsee			22. Name and A HEN	ddress of Facility RY W. JEN	KINS A	ND SON	S COM	PANY	
	-10		23e. Pert1. Enter the dis shock, or heart feile	eese, or con	nplications thet ceused	the death.	Do not					Ap	proximate ervel Between	
	/Medical Examiner	xaminer	Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list condition if any, leeding to immediceuse. Enter Underlying	ns,	b	Due to (or	es e cor	sequence of):	Aria					
0x 68/60,	The law requires that the death cartificate be axecuted attentions been signed by the attending physician and page 2 should be detached for use as the burial-trensit	n/Medical Examiner	ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest	{	d	Due Io (or o	es e con	onsequence of):						
0	daath e atte	sicia								23h Did t	obacco usa co	ntribute to the	cause of death?	
, r.O. box	that the death car ned by the attendir a detached for use	by Physician/M								23b. Did tobacco use contribute to the cause of de 1 Yes 2 No 3 Probably 4 Unk				
Hecords,	aw requiras t s been signe 2 should be	Completed b								24e. Wes : perfor	an eutopsy med?	eveileb	utopsy findings le prior lo ition of ceuse	
	The lav	шо								101	es 25No	1 Ve		
		Be	25. Wes cese referred to examiner?	medical					26. Plece of Dee	th (Check only o	ne)			
5	this co	2	1⊠ Yes 2□ No		Hospital: 1 ☐ Inpatie		-	tient 3□ DOA		ome 5 Resid				
5	After funar	tion		Pending investigation	28a. Date of Injur	Year)	8b. Tim Inju	9 of 28c.	njury et Work? 1 □ Yes 2 ☐ No	28d. Describe h		•		
2	Attending Physician: r death. ctor: After this certific. by the funaral director,	ertification:		Could not b				114			treet and Numb			
5	0 0 0	Cert	4 ☐ Homicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)								28f. Location (Street and Number or Aural Acute Number, City or Town, State) 4307 FPANK FORD AUG MACTUON			
(RB	Heolbe	29a. Certifier 1 (Check only one)	Certifying Ph ledical Exam	vsician: To the best of	of my knowl	edge, de	eth occurred at th	e time, dete end place, ny opinion, death occur	and due to the o	euse(s) and me	enner es stated		
1	P S	2	29b. Signature and title o	certifier	4			29c. Lic	ense number		29d. Dete signe	d (Month, Day,	Year)	
		2	Jugay	rta	mey6, 18	2		0	.C.M.E.	F	EBRUARY	22,199	8	
			30. Name end address of MDM DM	Α	completed cause of de	eeth (Item 2			enn Street,					
	Sta Registr		31. Date filed (Month, Da	7, Year)	8 32 magira	Davids	10 PB							

Registrar DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Month **Physician** FLORENCE M. WHEELER 4b. City, Town, or Location of Death /Medical 4a. Facility Neme (If not institution, give street end number) 4c. County of Death Examiner 6003 HUNT RIDGE RD. BALTIMORE BALTIMORE Hours Min. 8. Dete of Birth (Month, Day, 08/12/ Birthplace (Stata or Foreign Country) If Under 1 Yeer 5. Sociel Security Number 6. Sex 7. Aga (In yrs. last birthdey) Funeral Months Deys 1 M 2 XF 79 Yrs. 213-68-4398 1918 Director ALABAMA Usual Rasidance of Decedant with the Merylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Nems 23a or 28a-f show other traumatic event, the Medical Examinar trans to motified at 1 Yas ZEINo Director BALTIMORE BALTIMORE MD 10a. Straat end Numbar 10f. Zip Coda 10g. Citizan of What Country? 6003 HUNT RIDGE RD 21210 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Datas: Raca - American Indian, Biack, White, etc. Wes Decedant of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) permit. Peges 1 and 2 should be filed within 72 hours after c. Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yas 2 No Š Specify: 3 Widowed 4 □ Divorced WHITE Completed 18a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 4YRS HOUSEWIFE HOMEMAKER 17. Fethar's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be GEORGE MURRAY BLUE OLIVER 2 19a. informent's Neme/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) REXFORD L. WHEELER III(SON) 115 HAWTHORN RD. BALTO., MD. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 Cramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify) GREEN MOUNT CREMATORY02/24/98 BALTO., MD. 21. Signature of Funarai Sarvice Licenses 22. Nama and Addrass of Facility HENRY W. JENKINS & SONS CO. 161 4905 YORK RD. BALTO., MD. 21212. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** /Medical Immediata Ceusa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a co Examiner physiclen and s the buriel-transit Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or Injury thet initieted evants resulting in daath) Last Dua to (or as a cons Box 68760, Physician/Medicai 88 attanding esn signed by the atta Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably Onknown 1 | Yee 2 | No by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed page 2 has 2. No certificate 1 Yas 1 ☐ Yes 2 No Attending Physician: 25. Was casa referred to medical Be 28. Place of Death (Check only ona) 12 Tas 2 No Other: 4 Nursing Homa 5 Pesidence 6 Othar (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this luneral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Dascribe how injury occurred Certification: 28b. Time of 28c. Injury at Work? Aller 5 Panding investigation 1 Natural death. 1 Yas 2 No 2 Accident 2 Director: 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 5 4 Homicida × 1 Certifying Physician: To tha best of my knowledga, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

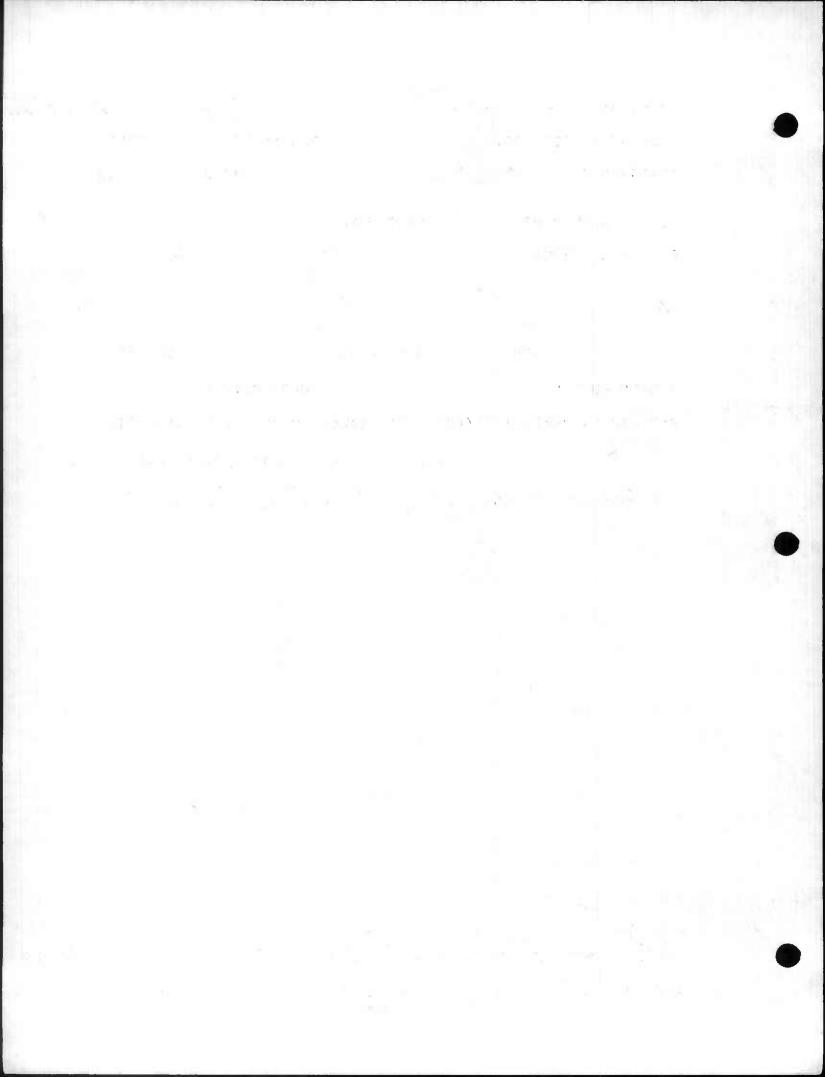
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Cartifier Medical 8 29b. Signatura and title of contilion 29d. Data signed (Month, Day, Year) 29c. Licansa numbar 30. Nama and address suse of daath (Item 23a) (Type, Print) 31. Deta filed (Month, Day, 4/1/40 Year) intrer's Signatura State

DHMH 16 Rev 6/95

Registrar

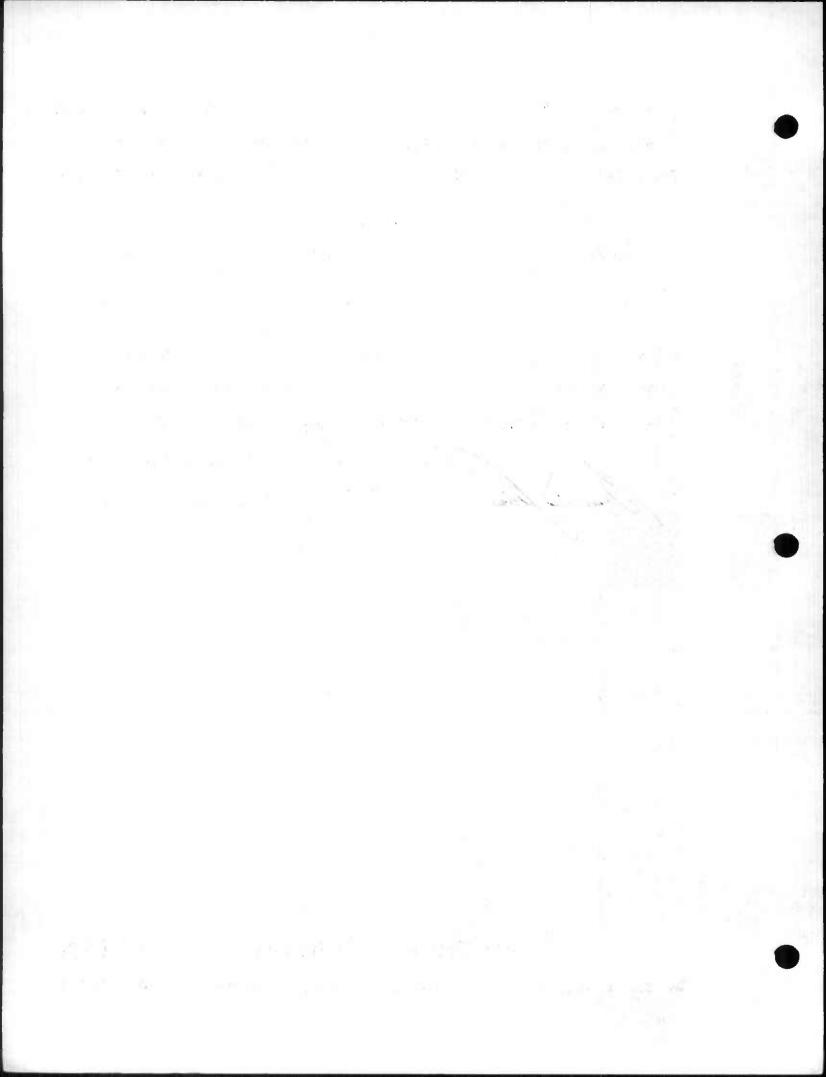
1998

03



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** 1998 Amanda Yeager March 6:10 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Eldercare- Perring Parkway Baltimore If Undar 1 Yaar Months Days if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Oct. 27, 1906 5. Social Security Number 7. Age (in yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1□M 2ÅF Hours 216-07-1422 91 Maryland Director Usual Rasidance of Dacedent with the Maryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County r than "natural", or itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yas 2 □ No Maryland N/A Baltimore Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3201 Moravia Road U.S.A. 21214 death 12. Was Decedent Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or that any injury or other traumatic event, the Medical Examinations. Black, Whita, atc. 1 ☐ Yas 2 X No If Yas, Giva 1) Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: specify: White à 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Packing Company 6th grade Clerk 18. Mother's Nema (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) John Yeager (Surname Unknown) Tina 19e. Informent's Name/Ralationship (Type, Print) 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) John C. Yeager 720 Beretta Way, Bel Air, MD (nephew) 20b. Place of Disposition (Nama of atary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Sta Parkwood Cemetery 3/4/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) 22. Nama and Addrass of Facility Schimunek Funeral Home, Inc. 1000 9705 Belair Rd., Baltimore, MD 21236 blications that caused tha death. Do not antar tha mode of dylng, such as cardiac or respiratory arrest one cause on each line. Approximata tntarval Batween Onset and Death res/Wene bane Physician Immediata Causa (Final disaasa or condition rasulting in deeth) /Medical Examiner Dua to (or es e consequance of): Examiner burial-transi Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or Injury that initiated evants rasuiting in daath) Last and Dua to (or as a consequance of): physician the burial Box 68760 certificate be Physician/Medical Dua to (or as a consequanca of): 8 987 20 P.O. 8 detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably Unknown Division of Vital Records, þ 2 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy Completed D000 Pass page 2 certificate 1 🗆 Yas 2/2 No 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: 1 Yes 2 No Othar: ♦ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA Pris 28a. Deta of Injury (Month, Day Year) uneral 27. Mannar of Death 1 Naturel 28b. Tima of 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? 5 Panding Invastigation 1 Yas 2 No affector: A 2 Accidant 8 Could not be datermined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida To the Hospital of within 24 hours a To the Funeral D 29a. Certifian 🕰 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mennar as steted. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) D Baltimore, MD Dr. Zied K. mirza 3007 e. Northern Pkwy A2. Fredistra's Signature da 182 31. Data fliad (Month, Day, Year) State MAR 0 3 1998 Registrar



7 is marked other than "natural", or items 23s or 25s-f show traumatic event, the Medical Examiner must be notified at e filed within 72 hours aftar all Hygiens. altimore, Maryland 21215-0020 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any linyry or other traumatic event angs. Injury or other traumatic event angs.

> **Physician** rivication Examiner

requires that the death certificate be axecuted physician and is the burial-trans attanding I for usa as signed by the a been sig cartificata of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this cartific director funaral On Divisi

10g. Citizen of Whet Country? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Ricen, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give X Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Year or Dales Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) unemployed NA 12th Grade 18. Mother's Name (First, Middle, Malden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Sidney Young Yvonne Johnson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Hayward Young 17 Laura Lane Hopewell Junction, NY 12533 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete X Suriel 2 ☐ Cremetion 3 ☐ Removel from State Rosehill Cemetery 03-05-98 4 ☐ Donetion 5 ☐ Other (Specify) Putnam Valley, NY Baltimore, Maryland 21202 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Semand 2 rocally WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List by one cause on each line. Approximete Intervel Between Onset end Deeth Hand and fmmediate Cause (Finel disease or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medicai Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy Completed performed? 1 Yes 2 No 19 Yes 2 No 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 10 1 Inpatient 2 ER/Outpetient XX DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: Subject 5 Pending Shot 1 Netural 2-26-98 34 AM 1 ☐ Yes 2 ☑ No investigetion 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1300 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. edical 29a, Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26,1998 O.C.M.E FEBRUARY 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

3. Time of Deeth

1:57

Birthplace (Stete or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

NA

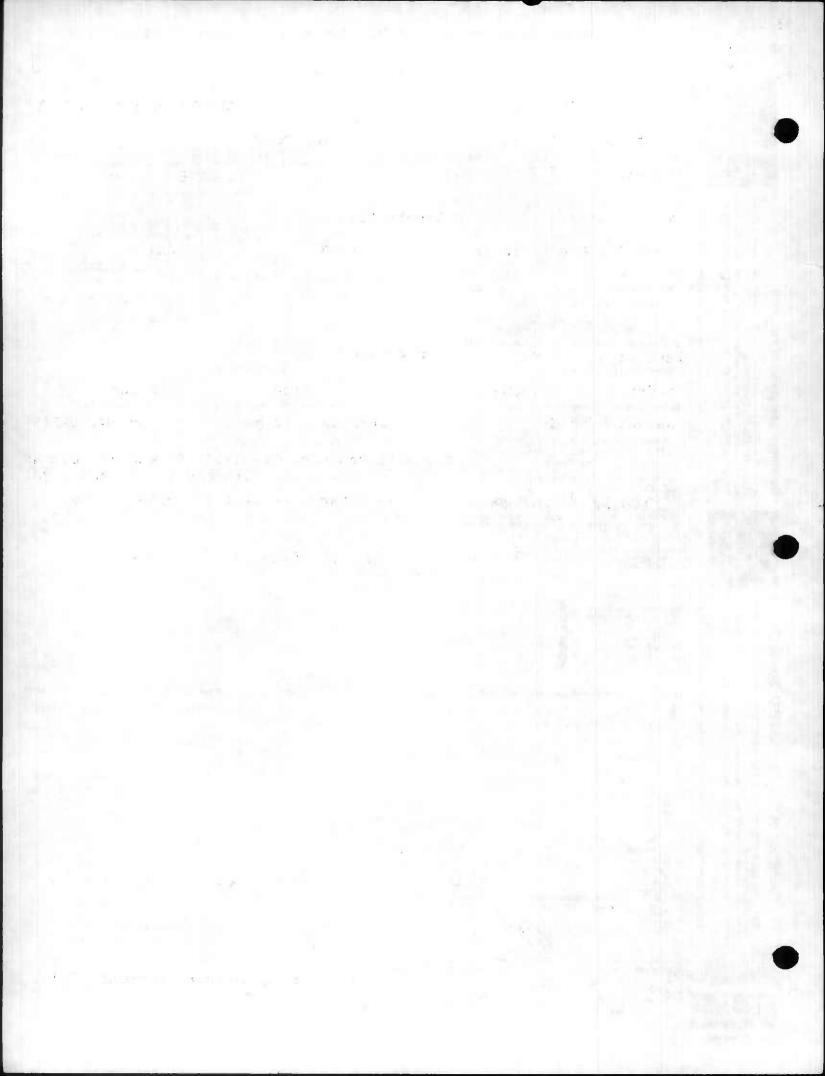
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State Registra Reble

32. Registar's Schalure
Juna Davidson-Aandell

24 hours

To the Hosp within 24 hou To the Fune completely fil



98-1029-510 UNK 98-044

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

6576

1 Yes 2 No

Approximate Interval Between Onset and Death

SIDNEY YOUNG SR.

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Fuquan Woo 26 1998 Young **FEBRUARY** 2:00 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL If Under 1 Year Birthplace (State or Foreign Country)
 N Y. 7. Age (In vrs. last birthday) 6. Sex Hours XM 2□ F Days Months 31 157-64-1524 06-06-66

Funeral Director

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

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with the Menylend death

7 is marked other than "natural", or hems 23a or 28a-f show traumatic event, the Medical Examiner must be notified all

e filed within 72 hours efter of Hygiene. permit. Peges 1 end 2 should be f Depertment of Health end Mentel I Important: If Nem 27 Is marked of any Injury or other traumatic eve Baltimore.

> **Physician** /Medical Examiner

certificate be executed physicien end s the buriel-trans Physician/Medical 98 use for the signed by t Completed peen hes certificate director this funeral Certification: Attending death. of Attended à

Box 68760

Records.

Division of Vital

JOHNS HOPKINS 5. Social Security Number Usual Residence of Decadent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Md Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3015 Oak Green Circle 21243 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2½ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. ¥ Never Married 2 Married 1 Yes 2000 Specify: 3 ☐ Widowed 4 ☐ Divorcad Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unemployed 12th Grade Na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sidney Young Yvonne Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hayward Young 17 Laura Lane Hopewell Junction, NY 12533 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State to Burial 2 ☐ Cremation 3 ☐ Removal from State Rosehill Cemetery 03-05-98 Putnam Valley, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licenses D May mon WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List party one cause on each line. Immediate Cause (Final Head Gunshot Wound disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 □ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

11 Yes 2 No

29a. Certifier

(Check only one)

27. Manner of Deeth 1 Naturel 5 Pending 2 Accident 3 Suicide 4 Homicide

investigation 6 Could not be determined

28b. Time of 28a. Dete of Injury (Month, Day Year) 2-26-99

Injury 134 AM 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) sneut

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA 28c. Injury at Work? 1 Yes 2 No

29c. License number

28d. Describe how injury occurred Shot 545,ect 281. Location (Street and Number or Rural Route Number, City or Town, State)

1300 BUE Mentfund 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end plece, end due to the cause(s) end manner stated.

29b. Signature and title of certifier

O.C.M.E

29d. Date signed (Month, Day, Year) FEBRUARY 26, 1998

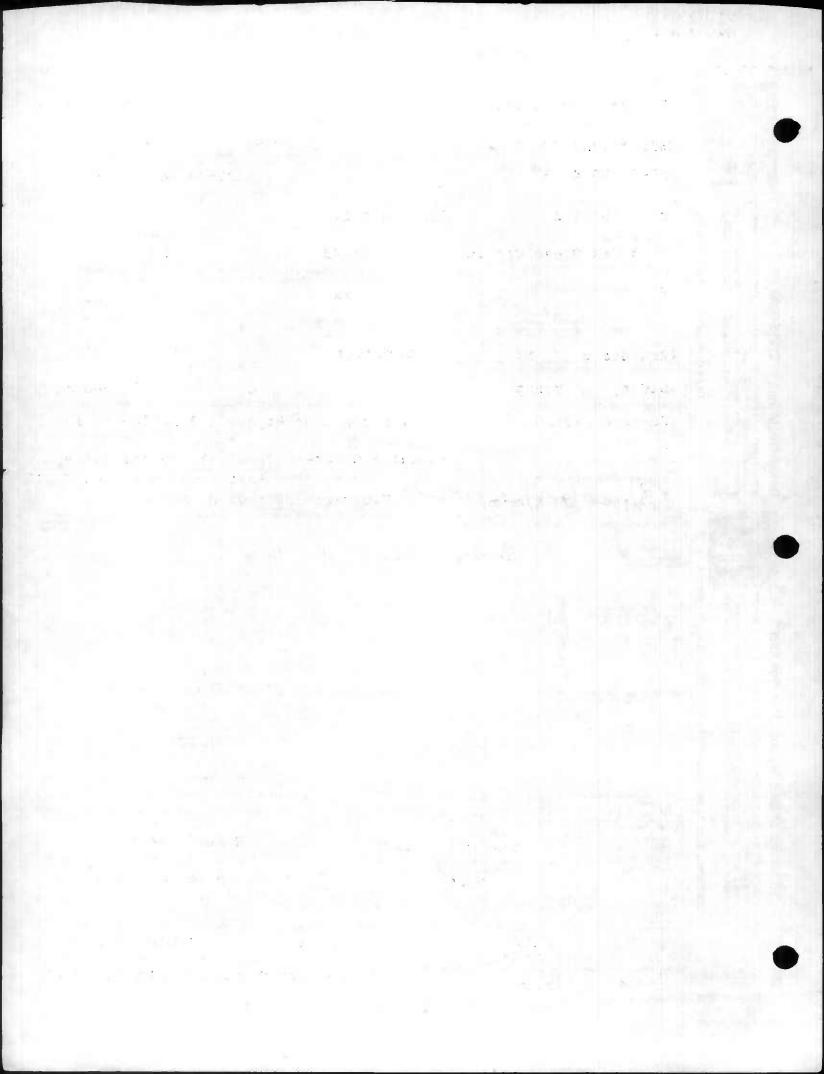
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Penn Street, Baltimore, Maryland 21201 Forter

State Registrar 31. Date filed (Month, Pay, Year) MAR 0 3



Funeral

To the I within 2.



				State of	Maryland /		tificate of		aliu ivi		Reg. No.	U6	5/1
	Physic		Decedent's Name (First, Middle, La Mary E	stelle	Adams					2. Data of Das Month 02	Day 18	Year 98	3. Time of Death 6:51PM
	/Medi Examii		4a. Facility Name (If not institution, given CAROLINE NURSING	e street and numi				4b. City, To		cation of Death	4c. County		
	Funeral Director		5. Social Security Number 6. S 216-54-9973		. Age (In yrs. last 104	birthday) Yrs.	if Under 1 Yaar Months Days	If Undar	24 Hrs. Min.	8. Date of Birtl (Month, Day April 1	7 Year) 8, 1893	9. Birthpl Count Mar	aca (State or Foreign ry) 'Yland
Baltimore, Maryland 21215-0020	Pages 1 and 2 should be titled within 72 hours after death with the Maryland nent of Health and Mental Hygiena. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show ity or other traumatic event, the Medical Examiner must be noticed at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number 221 South Third 11. Marital Status 1 Newer Married 2 Married 3 Widowad 4 Divorced 15. Decedent's E (Specify only highest gri Elementery/Secondery (0-12) 8 17. Father's Name (First, Middle, Last Louder 19a. Informant's Name/Relationship (Mary L. Conner 20a. Method of Disposition 1 Neurial 2 Cremation 3 C 4 Donation 5 Other (Specil	Street 12. Was Deced Armed Ford 1 Yes 2 1 If Yes, Give Yaar or Dat ducation College (1-4) Layton Type, Print) Nie	Adams Adams 20b. Place cemes	6a. Deceder (Gha life. L. Home) 9b. Mellin 221 9 of Dispositery, crem	Inf. Zip Code 21629 Vas Decedent of It Yes, specify Cut I Yas 2X No Jent's Usual Occur kind of work dona emaker g Address (Stree South The sition (Name of natory or other pile	pation during mosical 18. Mother and Number Sird Since)	t of working state of the state	city Yas or No- Rican, etc.) (First, Middle, Y COU.)	Specify Cauc Specify Cauc 16b. Kind of Be HOI Maiden Surnam 1by r, City or Town,	Mhat Count State e - Amarica ck, White, e casial usiness/Ind me ne) State, Zip yland City or Tox	es an Indian, old. nustry Code) 21629
	Pemit. Peges Pepatment of Important: If Important: If I important in I imp		23a. Part1. Enter the disease, or comshock, or heart failura. List only Immediate Cause (Final disease or condition rasulting in death)	plications that cau	one used the death. D	22 M 1 Do not ente	Name and Addr. Name and Addr. Name and Addr. Name and Addr. South The mode of dy.	ess of Facilit neral Seconding, such as	Home d Sti	, P.A.		Maryl	and 21629 Approximate Interval Between Onset and Death
Box 68760,	deeth certificate be axecuted e attending physician and ed for use as the buriel-transit	in/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	b	Due to (or as								
P.O.	es thet the digned by the	t by Physician/M	Part II. Other significant conditions of	ontributing to deal	an ter	g in the ur	derlying cause gl			101	res 2 No	3 Prob	the cause of death?
Records,	0 - 0	Completed								24a. Was a perfor	med?	eva con of c	re autopsy findings ilable prior to npletion of cause leath?
	To the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this certificate completaly filled in by the funeral director, page	Medical Certification: To Be C	25. Wes case referred to medical examiner? 1 Yas 2 No 27. Manner ot Deeth 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28e. Pleca o building	Injury Day Year) Injury - At home, c, etc. (Specify) est of my knowled is of axamination	ige, death	28c. inju Wc M 1 ==	me, date an	No 2	28f. Location (S City or Tow and due to the cod at the time, cod	ence 6 Oth ow Injury occur intreet and Numb n, Stata)	per or Rural enner as strend due to	Route Number, ated. the cause(s)
,			30. Name and address of person who WAFIK ZAKI SHO		of death (Item 23)			BOX	496,	920 MA	RKET ST	DEN	TON, MD

Registrar

FEB 20 '98

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of We		Certifica				Reg. No.	065	578
Physic /Med		1. Decedent's Neme (First, Middle,	OPE AI	dams				2	Februa Dey 16	98	Time of Deeth
Exami Funeral	Д	214-36-3359	- Hre	YUL — a (In yrs. last birt	hdey) If Unc Month	der 1 Yeer	4b. City, Town, or Loca If Undar 24 Hrs Hours Min	5. 8. Date of Bir (Month, De	/ Ci	9. Birthplece Country)	(State or Foreign
M W M	1	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Location				-		inside City Limits
the Marylar 28s-f show notified at	ctor	Maryland Charles		Indian	Head					t	¥ Yes 2 □ No
P C P	Director	10e. Streat and Number				Zip Code			10g. Citizen of V	Whet Country?	
20 ahar death with the Marylo or items 23s or 28s-f shor iminer must be instiffed at	Funeral	68 Circle Ave.	12. Wes Decedent E Armed Forces?	Ever In U,S.		0640 cedent of I	Hispanic Orlgin? (an, Mexican, Pue	Specify Yes or No	U.S.A.	e - Amarican Ir	ndien,
ours after rest, or its	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced		io		2₩ No		to rican, etc.)	Specify	white, etc.	
21215-0020 d within 72 hours at giens. r than "matural", or the Medical Exam	Completed	15. Decedent's (Specify only highest (Specify only highest (Specify only highest (O-12))	Education rede completed) College (1-4or 5-	+)	Decedent's Us (Give kind of v life. DO NOT		petion during most of wo d)		16b. Kind of Bu		c School
	Be C	17. Fether's Nema (First, Middle, La	st)	10	ou ber	vice	18. Mother's Na	me (First, Middle	-		C DOING
	70	John Lee Abell						Elizabet			
re, Maryli s 1 and 2 should f Health and Mei fem 27 is marks other traumatio		19e. Informent's Neme/Relationship					end Number or R				ie)
of Hear		Gary W. Adams 20e. Method of Disposition	Sc	20b. Plece of	Disposition (A	lgly leme of rather ple	Ave., In February	Date 1000	20c. Location -		State
Baltimore bemit. Pages 14 Department of He mportant: If Item iny injury or oth		1 Buriel 2 □ Cremetion 3 4 □ Donation 5 □ Other (Special		St. Ch	arles (Cemet	rebruary erv	18, 1998	Indian	Head,	Maryland
Baltimore, N pemit. Pages 1 and Department of Health Important: if item 27 any injury or other its once.		21. Signeture of Funeral Service Lic	ensee		22. Name Willia	end Addre	ess of Facility uneral H orne Rd.			Md 206	340
		23a, Part1. Enter the discuss, or co shock, or hear talking. List on	mplications thet caused ly one ceuse on eech lin	the deeth. Do n	ot enter the m	ode of dyl	ng, such es cardia	c or respiretory e	rrest,	App	proximete ervel Between sat end Deeth
Physician /Medical Examiner	er	Immediate Ceuse (Final disease or condition resulting in deeth)	6	CE P		_	tu u	TERU	2		at one been
68760, tificate be executed g physician and as the bunal-transit	Examiner	Sequentiatly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or es a c	onsequence o	f):					
E 0 8	//Medicai	Ceuse (Disease or injury thet initiated events resulting in deeth) Lest	c	Due to (or es a c	onsequenca of	f):					
death cent death cent e attendin ed for use	Physician/N	Pert II. Other eignificant conditions	contributing to death bu	t not resulting in	the underlying	cause di	ven in Part I.	23b. Did	tobacco uea co	ntribute to the	cause of death?
ords, P.O. Box requires that the death cer een signed by the attendir hould be detached for use	by Phys					,			Yes 2□ No	3 Probably	4
S S S	Completed							24e. Wes	an autopsy ormad?	eveileb	tutopay findings te prior to ution of cause h?
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of Vital Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical exeminer?	Hospital: 1 ☐ Inpatier	A □ EB/O	mations OF I	Oth	or.	eth (Check only		10	
0 5 5 7	-	27. Manger of Death	28a. Date of Injung (Month, Dey	28b. T		28c. Inju		Home 5- Hesi 28d. Describe	how injury occur		
DIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	1-ANaturel 5 Pending 2 Accident investiget 3 Suicida 6 Could not 4 Homlotde determine	on be one Bloom of Initial	rv - At home, far	М	1 🗆	Yes 2 □ No	28f. Location (City or To	Street and Numb wn, State)	er or Rurel Rou	uta Number,
DIVI To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying F	Phyeician: To the best of aminer: On the besis of end manner stet	examination and	death occurre Vor investigation	ed at the tir on, in my c	me, dete and place optnion, deeth occ	e, and due to the urred et the time,	cause(s) and ma date and plece, o	nner es steted and due to the	cause(s)
To the To the compl	Me	29b. Signeture end title of certifiar	m 120	h		9c. Licens	se number	2	29d. Dete signed	1 (Month, Day,	Year)
		30. Name end eddress of person wh	completed cause of de	eth (Item 23e) (*		PL	sta	md	20	646	,
Sta		31. Dete filed (Month, Day, Year)	998 32. Begistre	r'a Signature	Cardo H.						

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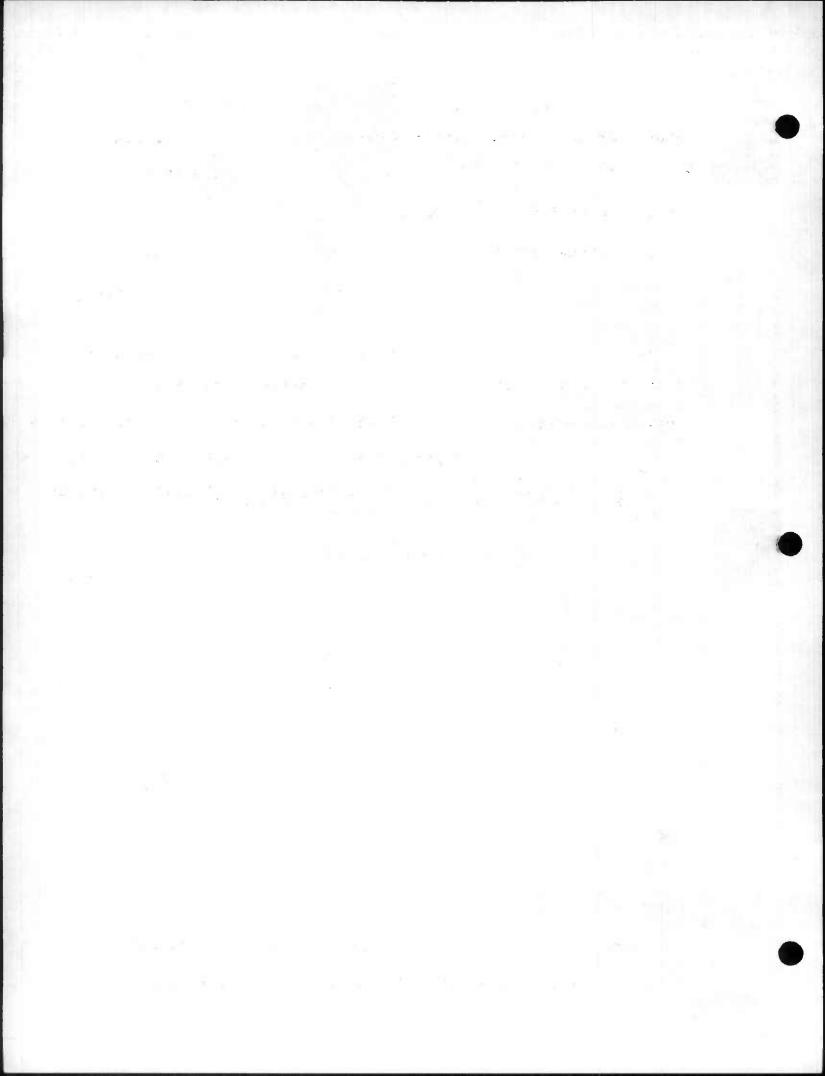
State of Maryland / Department of Health and Mental Hygiene 8 06579

					Cert	ificate o	f Death		В	eg. No.	0 0	OJI.)
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Exam		4e. Fecility Name (If not institution, give	street end number)				4b. City, To	wn, or L	ocation of Deeth	4c. Co	unty of Deeth	h	
		Mariner Health o	f Forest	Hill					Hill	Ha	arford		
Funera Directo		255-07-1445	7. Age	(In yrs. lest bird	, out	Months Day		24 Hrs. Min.	8. Date of Birth (Month, Dey Aug. 1	, Yeer) 5, 19	9. Birth Cou	nplece (Stete cuntry) st Virg	inia
anyland	2	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loca	ation						10d. Inside C	ity Limits
he M	Director	Maryland Harfor	rd	Str	reet	101 7: 0: 1				0	4100 . 6		201140
23a or		315 Cherry Hill 1	Road			10f. Zip Code 211				og. Citizer	usa USA	untry?	
Datititiore, Midryliand 21213-0020 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, he Neptent Exeminar must be notified at	by Funeral	11. Marltal Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		lf Y	as Decedent o Yes, specify C ☐ Yes 2⊠N	uban, Mexicen	gin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Bleck, White pecify:		
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permit. Popertmi importar		21. Signature of Funeral Service Licens		UTTTO	22.1	Service Name and Add Oward K	dress of Facilit	tv.	2–23–98 III Fun			aryland	1
20296		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o	myello lications that caused	the death. Do r	50	O W Br	madway	Str	reet Be	1 Air		rland 2	te
Physician /Medica Examine		Immediate Cause (Final disease or condition		e. laste								Intervel Bet Onset and	
		resulting In death)		Due to (or es e									
o executed an end iniel-transi	Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	b	Due to (or es e o	conseque	ence of):							
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or Attanding Physician: 7 effer deeth. Director: After this certifical I in by the funeral director, p	ation	1 Natural 5 Pending 2 Accident Investigation	28a. Dete of Injur (Month, Dey	Year) 280. I	Time of njury	28c. lr V M 1	Vork? □ Yes 2□	No	28d. Describe h	ow injury o	ccurred		
To the Hospital or Attanding Ph Within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ry - At home, fa . (Specify)	rm, stree	et, factory, offic	ce		28f. Location (S City or Tow		lumber or Ru	rei Route Nun	iber,
To the Hospital of within 24 hours expensed To the Funeral Discompletely filted is	edicai	29a. Certifier 1 Certifying Phy cone) 1 Medical Exami	aician: To the best o ner: On the basis of end menner sta	examinetion en	death o	occurred at the estigation, in m	time, date an y oplnlon, dea	d place, th occur	end due to the o	ause(s) an late end pl	d manner as ace, end due	steted. to the ceuse(s	s)
Vithin To the	¥ e	29b. Signeture end title of certifier				29c. Lice	ense number		2	29d. Dete s	signed (Month	h, Dey, Year)	
		Daus 5	Dun			D32299 February 19, 1558					18		
Ø		30. Name end eddress of person who ca		eeth (ttem 23a) (0.1	- 1				1		
St	ate	31. Date filed (Month, Day, Year)	32 Registra	r's Signeture		ac a rid							

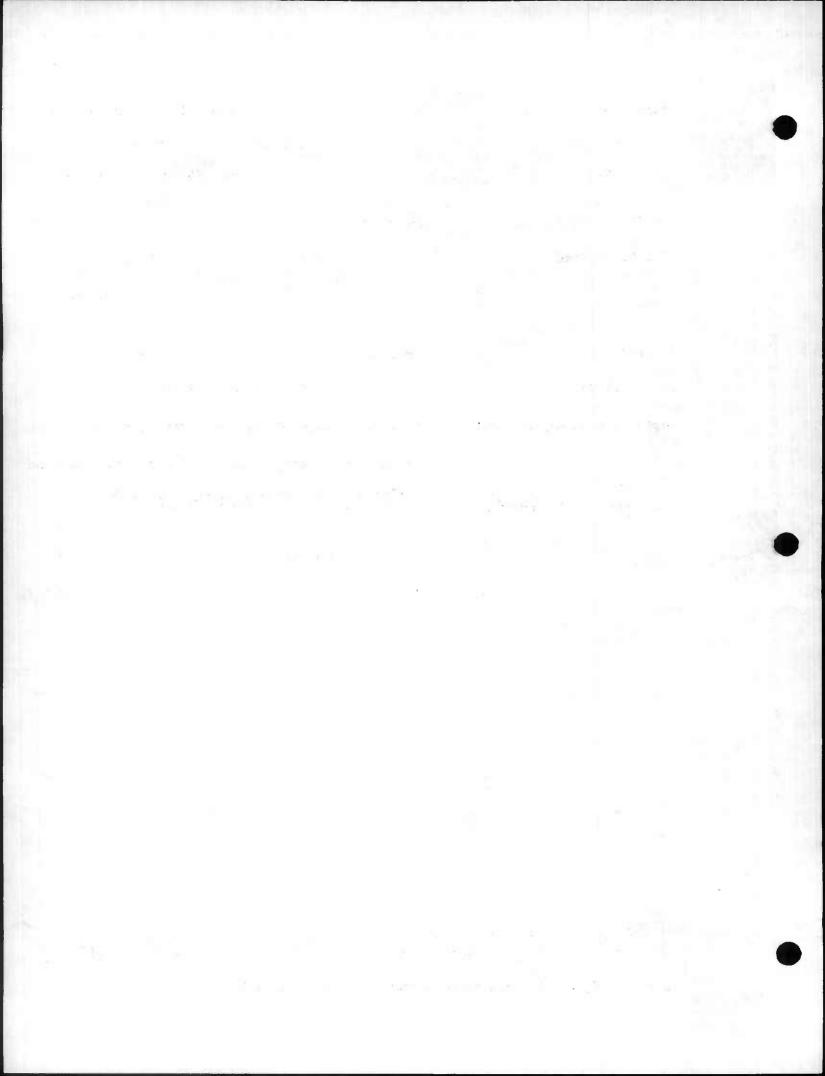
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Feb. 13 Dey 1998 Marguerite duPont Brinkley 7:05PM /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Shore Nursing & Rehabilitation Cent. Denton Caroline 5. Sociel Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** 1□M 2XF Deys 577-28-1208 86 Yrs Director Usuel Residence of Decedent the Marylend 10e. Stete 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Md. Caroline Denton 1 Tyes 2 XNo Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 27515 Anthony Mill Road 21629 USA Completed by Funeral 12. Wes Decedenl Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: White 3 Widowed 4 □ Divorced the Madical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 7 is marked other than traumatic event, the Me Hygiene. College (1-4or 5+) Administrator Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) . Peges 1 and 2 should be fill ment of Heelth end Mental Hant: If Item 27 is marked oth jury or other traumatic even Be Charles Louis Martin Lottie Irene Graves 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Daughter - Patricia Gordy 27515 Anthony Mill Rd., Denton, Md.21629 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial ②☐Cremelion 3 ☐Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Pege Depertment of Important: If any injury or Capital Crematory 2/14/98 Dover, Del. 21. Signature of Funerel Service Licen 22. Neme end Address of Fecility Moore Funeral Home, P.A. 12 Denton, Md. 21629 2nd St. 23e. Perfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List this one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** e. Congestive heart failure
Bue to (or es e consequence of): /Medical Immediete Ceuse (Final diseese or condition resulting in death) Examiner 2 Weeks Examiner PACUMONIA The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest end Due to (or es e consequence of) P.O. Box 68760. Physician/Medicai Due to (or es e consequence of): for use as Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by pege 2 should be detact 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were eutopsy findings evellable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 □ Yes 2 □ No certificate To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Deeth 1 Maturel 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Division 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 critifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical 29b. Signeture end litle of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 2/13/98 Volu MD 1005/132 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Jorge H. Abrego 660 Daffin Lane, Denton, Maryland 21629 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature State Lulia Sairdson-Ran FFR17 Registrar



								Death			giene) 8	U	6581
Physic	ian	1. Decedent's Neme (First, Middle, Las	t)							2. Dete of Dee	eth Dey	Year	3. Time of Deet
/Med		Mabel Lee Bart								Feb		998	9:30 a
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Funeral Director			M 2∏ F	70	Yrs.	Months	Deys	Hours	Min.	8. Date of Birt (Month, De) June 2	, Year) 5 1927		place (Stete or Fore ntry) ginia
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28	Director	10e. Street end Number	Airic		Queel	1 Anne	_			T	10g. Citizen of V	Vhet Cou	intry?
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Haalth am 27 I		Edwin C. Bartley	husba					oad ((ueer		Maryla		
or other		20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □	Removei from		Plece of Disponentery, cre	osition (Ner metory or o	ne of ther pla	ce)		Dete	20c. Location -	City or T	own, Stete
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Departmen important: any injury ance.		21. Signeture of Funerel Service Licens	800		ess of Fecility	•	. 17	-1 77-	D.A				
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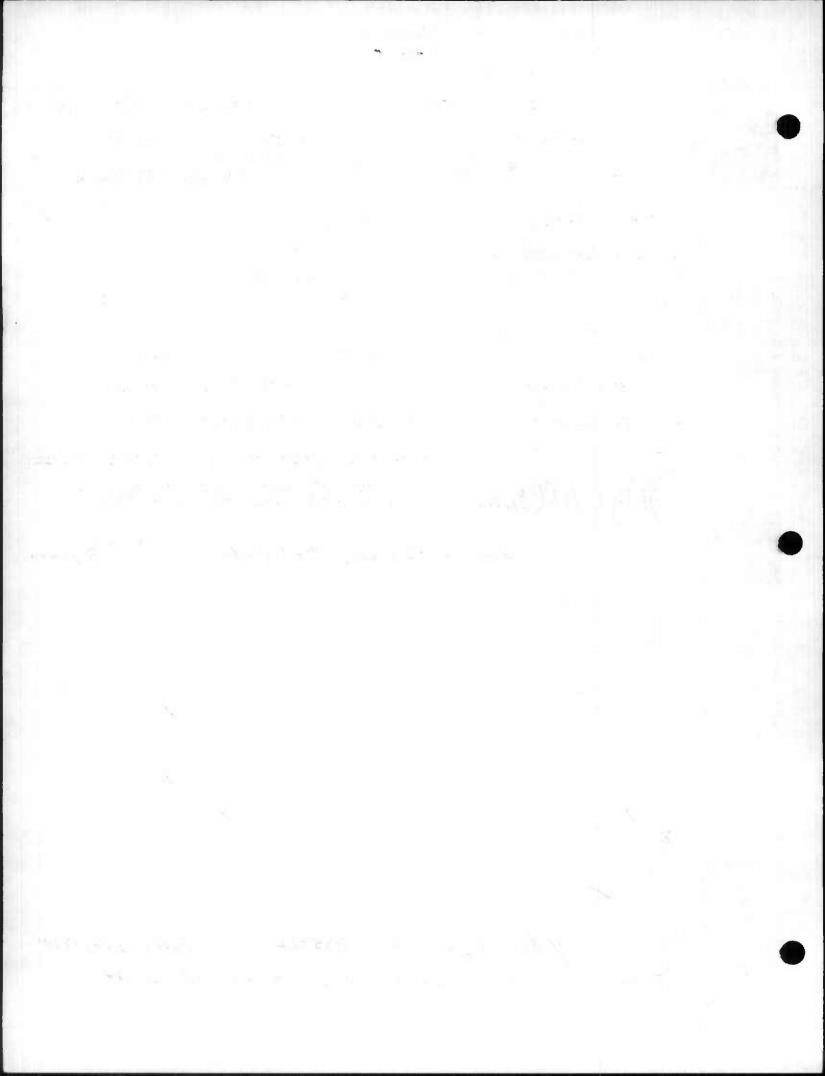


Physician //Medical Examiner Per use of the disease or condition resulting in death) Pure to (or as a consequence of): Due to (or es a consequence of):						or Maryland /		ficate of		vientai ny	Reg. No.	3 0	6582		
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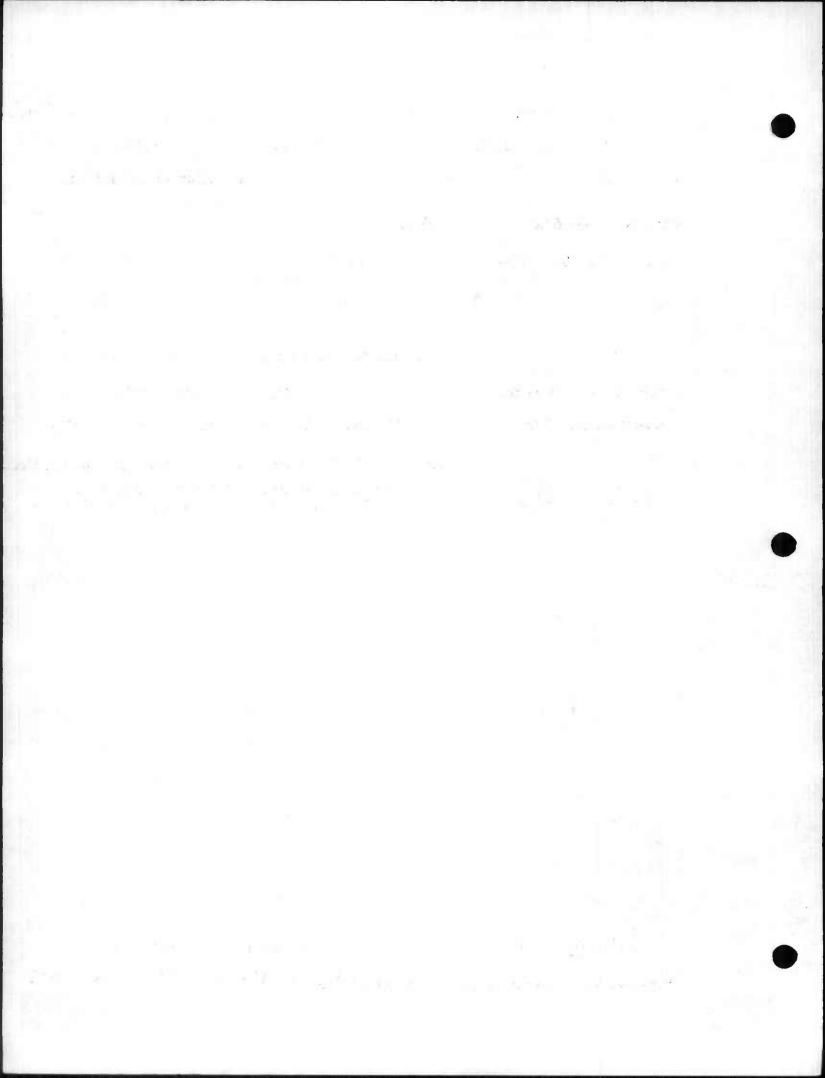
State of Maryland /-Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** LOUISE FRANCES BLEVINS February 14, 1998 12:50 AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 100 West Ring Factory Rd. Harford 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** 1□ M 20%F Deys Hours 213-28-8806 Yrs. 68 Director Aug. 27, 1929 Maryland Usuel Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar insist be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 100 West Ring Factory Rd. 21014 USA death 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) should be filed within 72 hours after ond Mental Hygiene.
marked other than "natural", or ite. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Item Z7 is marked other any Injury or other traumatic event ones. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Guy Leroy Perkins Zollie Frances Perkins 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Gordon A. Blevins - Son 1915 Neal Rd., Pylesville, Md. 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other piece) 20c. Location - City or Town, Stete 1 ⊠ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Upper Cross Rd. Baptist Cem. 2-18-98 Baldwin, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility
Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, MD 21014 mas Enter in disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or he in failure. List only one cause on each line. Onset and Deeth **Physician** Uterine CANCER, metastatic. /Medical Immediate Ceuse (Final 3 years disease or condition resulting in deeth) Examiner Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): ettending physiclan for use es the burie Box 68760 Physician/Medical Due to (or es e consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by t 1□ Yes 2X No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings evelleble prior to completion of ceuse Completed 24a. Was an autopsy performed? pege 2 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certification filled in by the funeral director; 25. Wes case referred to medical Be 26. Place of Death (Check only one) exeminer? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? 28b. Time of 1 Anaturel
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) February 16, 1998 D35012 10 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) 2 NORTH AVE. Belfir, Md. 21014 J. KEVIN LYNCH MO. 31. Date filed (Month, Dey, Year)
FEB1 (32 registrar's Signature State Registrar



Please Type or Print in Biack indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

		Certificate of	f Death	Re	g. No.	00004								
Physic	ian	1. Decedent's Neme (First, Middle, Last)		2. Dete of Deeth		3. Time of Dee								
/Medi		Nettie Marquette Bell		Feb	17 19	98 3.04								
Exami	ner	4e. Fecility Neme (If not institution, give street end number)	4b. City, Town, or	Location of Deeth	4c. County of	Deeth								
		Mariner Health of Bel Air	Bel Air		Harfo	ord								
Funeral		5. Social Security Number 6. Sex 1 □ M 2反 F 7. Age (In yrs. last birthday) ft Under 1 Yes Months Dey			Year) 9	. Birthplace (State or For Country)								
Director		215-10-9646 Sylver Residence of Decedent		Nov. 4,	1914	Maryland								
and and		10a. Stete 10b. County 10c. City, Town or Location				10d. Inside City Lir								
Vany f sh	0	Maryland Harford Bel Air				1 ☐ Yes 2 💆								
the 128s	Directo	10f. Zip Code		10	g. Citizen of Whe	et Country?								
A Mile														
in 2	Funeral	2411 Eagle View Drive 21015 11. Meritel Stetus 12. Wes Decedent Ever In U.S. 13. Was Decedent of		Specify Yes or No-	US 14. Rece -	American Indien,								
The start of	Ē	Armed Forces? If Yes, specify Cu		to Rican, etc.)		White, etc.								
72 hours after death with the Maryland 72 hours after death with the Maryland netural; or Hems 23s or 28s-f show dical Examiner must be notified at	þ	38 Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 □ N	lo Specify:		Specify:	White								
2 ho	Completed	15. Decedent's Education 16a. Decedent's Usuel Occ	cupetion	. 1	6b. Kind of Busin	ness/Industry								
Pin 7	ple	(Specify only highest grade completed) (Give kind of work don life. DO NOT use retired in the property of the	ne auring most or wo ired)	rking										
N Signal	P	12 Medical Record	ds Clerk		Health (Care								
S S S S S S S S S S S S S S S S S S S	Be	17. Fether's Neme (First, Middle, Last)	18. Mother's Ner	me (First, Middle, M	le <i>iden S</i> umeme)									
Went Went by Wilcon	2	Charles M. W. Marquette	Nettie	(u/	k) Wah	1								
Maryland 21215-0020 d 2 should be filed within 72 hours aft th and Mental Hygiana. 7 is marked other than "natural", or fraumatic event, the Medical Event		19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street	et and Number or Ru	urai Route Number,	City or Town, Ste	ete, Zip Code)								
and and a		Edward C. Bell/Son 2411 Eagle	View Dri	ve, Bel A	ir, Mary	land 21015								
Battimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours efter death with the Marylan Department of Health and Mentel Hyglene. Important if liem 27 is marked other than "natural", or fleme 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition 1 □ Burlel 2 □ Cremetion 3 □ Removel from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other p	elece)	Dete 2	Oc. Location - Cit	ty or Town, Stete								
Battimore, emit. Pages 1 ar appartment of Haa mportant: if Ilem ? iny Injury or other itts.		4 Donetion 5 Other (Specify) Jarrettsville Ce	emetery 2	2-20-98	Jarretts	ville Marv								
alt mmit. ponty		27. Signature of Funeral Service Licensee 22. Name and Address of Facility												
0 88888		Howard K. McComas III Funeral Home, P.A 1317 Cokesbury Road, Abingdon, Maryland												
		23a. Pert1. Enter the disease, or compilications that caused the deeth. Do not enter the mode of d shock, or hear-failure. List only one ceuse on each line.	lying, such es cardia	c or respiretory arre	st,	Approximete								
Physician						Interval Between Onset end Death								
/Medical		Immediate Cause (Final disease or condition	r- eule	vec		>3Mow								
Examiner		Immediate Cause (Finel disease or condition resulting in death) Conjecture Hear Due to (or es a consequence of): My careful Lular	1			10 dan								
D #	Je L	myocarchal Infar	elion			10 can								
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DIVISION OT or Attending Physiatar death. Director: Attar this In by the funeral di	Certification:	1 ☐ Meturel 5 ☐ Pending (Month, Dey Year) Injury W	lork? ☐ Yes 2 ☐ No	28d. Describe hor	w injury occurred									
or Attending after death. Director: Afte	cat	2 Accident		29f Location (Str	and Number	or Rural Route Number,								
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certifical completaly filled in by the funeral director.	edical	29e. Certifier (Check only one) 1	y opinion, deeth occu	rred et the time, de	use(s) ena menn te end piece, enc	er as steled. I due to the cause(s)								
ithin of the	Ž.	The mornior diolog.	inse number	29	d. Dete signed (Month, Dey, Year)								
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1.				•		-								
		30. Name and address of person who completed cause of deeth (Item 23a) (Type Print) Kannachin Muhayi Mp 703 Revoluti	1 Pt 1	arro Do	Grace	MO 2167								
			00 - 1											
Sta	ate	31. Dete liled (Month, Dey, Xear). 32. Begistrer's Signeture												



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** F E B 1 9 9 8 DICKERSON 5:45 AM ROBERT /Medical 4a. Fecility Nama (If not institution, giva streat and number) 4b. Cify, Town, or Location of Deeth 4c. County of Death Examiner SHORE NURSING & REHABILITATION CTR. DENTON CAROLINE 7. Aga (In yrs. last birthdey) If Undar 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Director 215-26-5011 12/14/25 Maryland Usual Residence of Decedent with the Meryland 10a State 10h County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at Caroline Federalsburg MD Director 1 ☐ Yas 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 403 Old Denton Road 21632 United States items 23a death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural" ---- eny injury or other traumatic execution. X Never Marriad 2 ☐ Married 1 ☑ Yas 2 ☐ No If Yes, Give Year or Detes: 4 2 - 4 6 1 Yes 2 No Specify: specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Agriculture Farm worker 17. Fathar's Neme (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be John Prattis Ella Dickerson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Pruden/niece 125 Davis Lane, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Crametion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) 2/12 Hurlock, Maryland Eastern Shore Vet. 21 Signature of Funeral Service Licenses 22. Name end Addrass of Facility Framptom-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each lina. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Fine diseesa or condition resulting in deeth) Examiner Due to (or es e consequença of) Physician/Medical Examiner ettending physician end for use es the buriel-transit The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Due to (or as a consequence of): 98 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown been signed t should be det Records, Be Completed by 24b. Were eutopsy findings eveileble prior to complation of cause of deeth? 24e. Wes en eutopsy performed? pege 2 Caro-ene 1 ☐ Yes 2 1 certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

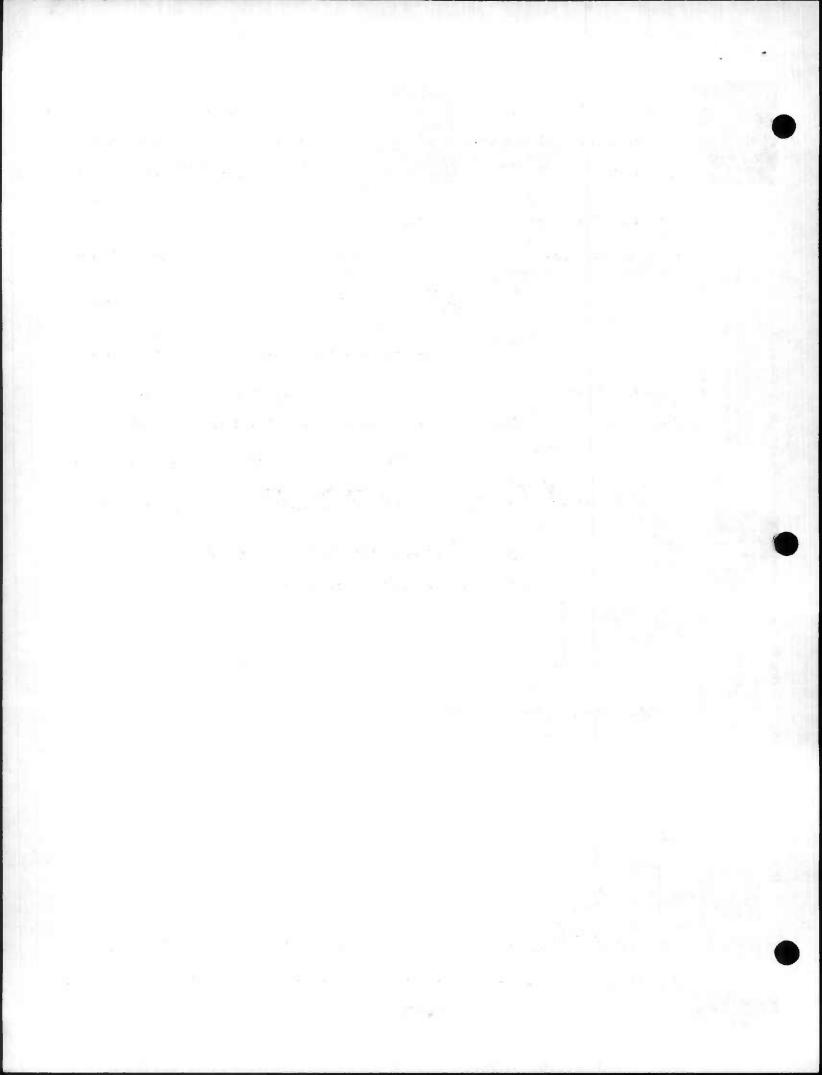
To the Funerel Director: After this certifica completely filled in by the funerel director, p 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Amersing Home 5 - Residence 6 - Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) end mannar statad. Medical 29a. Certifier 29b. Signeture and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) D32036 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GARY SPROUSE, M.D. 2108 DIDONATO DRIVE CHESTER, MD 21619 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar wha Davidson-Randall



State of Maryland / Department of Health and Mental Hygiene 9 8

_				Otato of IVI		Certificate		Death		eg. No.	U	0000
	Physic /Medi		Decedent's Neme (First, Middle, Las GURNEY LEWIS	•					2. Dete of Deat Month FEBRUAR	Dey	Year 998	3. Time at beath 12:05 AM
ı	Exami		4e. Facility Name (If not institution, give Frederick Memoria				4	b. City, Town, or Lo Frederic		4c. County	of Death	
	Funeral Director		5. Sociel Security Number 6. Se 215–44–1385	-	ge (In yrs. lest bir	thday) If Under 1 Months Yrs.	Yaer Deys	If Undar 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Oct. 30	Year)	9. Birth	plece (Stete or Foreign ntry) th Carolina
	yland wow		Usuel Residence of Decedent 10a. Stata 10b. County		10c. City, Town	or Location					T.	10d. Inside City Limits
	Sa-1 st	ctor	Maryland Frederi	ck	Mt. Ai	lry						1 ☐ Yes 2X No
	with th	Funeral Director	10e. Street end Number			10f. Zip 0			1	Og. Citizen of V		
	heath ms 23	neral	13349 Bottom Road	12. Was Decedant	Evar in U.S.		771	spanic Origin? (Spe	acify Yes or No-	Unite		ates can Indien.
21215-0020	72 hours after death with the Meryland natural, or items 23s or 28s-f show deal Examinat roust be noritled at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 If Yes, Give Yeer or Datas:		If Yes, specif		spanic Origin? (Spen, Mexican, Puerto Specify:	Rican, etc.)	Specify Specify	k, White, Wh	etc.
15-0	natur	eted	15. Decedent's Edi (Specify only highest grad	ucation de com <i>pleted)</i>	16a.	Decedent's Usuel (Give kind of work	Occupe dona d	etion luring most of works)	ing	16b. Kind of Bu		
212	I within 72 ho iene. r than "natur the Med cel	Completed	Elementery/Secondery (0-12)	Cotlege (1-4or:		nior Vice				Commer System		
pu	H T T T	BeC	17. Fathar's Name (First, Middle, Last)		, 501	1201 1200		18. Mother's Name	(First, Middle, A			ne.
yla		To	Lewis C. Dixon						Mae Ch	-		
Maryland	2 0 2 6		19a. Informent's Name/Reletionship (T) Janet Dixon	ype, Print) W ife				and Number or Rure				Code)
	무를		20a. Method of Disposition	WILE		Disposition (Neme y, cremetory or oth			Airy, I	MD 217 20c. Location -	-	own, State
imo	Pege nent o nnt: If		1 ☑ Burial 2 ☐ Cremetion 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify,	Removel from Stata)		Frove Cem			b. 14	Mt. Air	у, М	aryland
Baltimore,	permit. Peges Department of Important: If it any injury or o		21. Signature of Funeral Service Licens	000 CD17	un _		-Qu	een Funer				n 21784
,	Physician /Medical Examiner		234. Part : Priter the disaasa, or comp mock, or heert failure. List only o Immediate Ceuse (Finel disease or condition resulting in death)	e. ABULT SMAN		ot enter tha mode	of dying		or raspiratory arre	ast,		Approximata Interval Between Onset and Deeth
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of Vital Records,	aw requir	Completed							24e. Wes en		av	fere eutopsy findings yelleble prior to empletion of cause death?
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	To the Hospital or Attending Physician: within 24 hours effer deeth. To the Funeral Director: After this certifics completely filled in by the funeral director,	ation: To	27. Menner of Deeth Naturel 5 Pending Investigation	28e. Deta of Inju (Month, De	ry 28b. T		c. Injury Work	et Rursing Ho	me 5 ☐ Reside 28d. Describe ho		-	על
DIVISION	al or Atters setter de al Directo ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, fe c. (Specify)	rm, street, fectory,	office		28f. Location (St. City or Town		er or Run	el Route Number,
	he Hospil in 24 hour he Funera pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	alcien: To the best Iner: On the basis of end menner st	examinetion end	, deeth occurred et Vor Investigetion, In	the tim	e, dete end plece, oinion, deeth occurr	end due to the ca ed et the time, de	use(s) end me ete end piece, e	nner es s end due t	iteted. o the cause(s)
)	Tot Tot	W	29b. Signature and title of worthing	and				1761	29	9d. Data signad	1	
			30. Name and address of person who co	ompleted cause of d SNE A 32. Project	leeth (Item 23e) (Type, Print) W. SEVE	W/7.	4 ST. FI	RESERVE	KME) 21	701
	Sta Registi		31. Data filad (Month, Day, Yaer) FEB 13 1	998 32. Fraistr	er's Signature	Carlell				•		



98-0725-033 AM UNK.98-035 MICHAEL ERIC DRUMMING

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene of

Control Control and Monte	al Hygierie	U	5-	À
ficate of Death		U	U	9
modito of Dodin	Reg. No.			

1. Decedent's Name (First, Middle, Last) **Physician** /Medical

ERIC DRUMMING MICHAEL

2. Dete of Deeth Month Day Yes FEBRUARY

3. Time of Death

Examiner

4e Facility Neme (If not institution, give street and number)

6437 HILLMAR DR. PARKING LOT

4b. City, Town, or Location of Deeth

FORESTVILLE

14,1998 1255 P 4c. County of Deeth

Funeral Director

items 23s or 28s-f show iner must be notified at

Directo

Funeral

þ

Completed

with the Maryland

death

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than ***

Physician /Medical

Examiner

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signed b

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funaral director,

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After

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Hospital 24 hours

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physician certificata be

Box 68760

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Records.

Division of Vital

Examiner

Physician/Medical

by

Completed

Be

10

Certification:

Medical

10a State

1⊠M 2□ F Yrs 24

7. Age (in yrs. lest birthday)

If Under 1 Year Months Days

PRINCE GEORGES If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Hours Min. FEB. 25, 1973 WASHINGTON, DC

218-11-1551 Usual Residence of Decedent 10b. County

5. Social Security Number

MARYLAND PRINCE GEORGES

10c. City, Town or Location DISTRICT HEIGHTS

Cert

10d. Inside City Limits 15 Yes 2 □ No

10e. Street and Number

10f. Zip Code

10g. Citizen of What Country? U.S.A.

2701 LAKEHURST AVE.

11. Marital Stetus 1 Never Married 2 ☐ Married 12. Wes Decedent Ever In U,S. Armed Forces? 1 Yes 2 No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Raca - American Indian, Bleck, White, etc. Specify: BLACK

3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

20747

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

LANDSCAPER

PRIVATE

17. Fether's Neme (First, Middle, Last)

CRAWFORD LOWERY

18. Mother's Name (First, Middle, Maiden Surneme) VERONICA JANE DRUMMING

19a. Informant's Name/Relationship (Type, Print)

VERONICA DRUMMING / MOTHER

20b. Place of Disposition (Neme of cemetery, crematory or other place)

19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2701 LAKEHURST AVE. DISTRICT HEIGHTS, MD 20747 20c. Location - City or Town, State

20e. Method of Disposition

1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

HARMONY MEMORIAL PARK

2/21/98 HYATTSVILLE, MD

22. Neme end Address of Facility 3439 LIVINGSTON ROAD

THORNTON FUNERAL HOME, P.A. INDIAN HEAD, MD 20640

21. Significant Service Licensee
APDIA C. THORNTON JOHNSON

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediete Cause (Final disease or condition resulting in death)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest

Due to (or es e consequence of):

Due to (or as e consequence of):

Due to (or as e consequenca of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 Yes 2 No

24a. Was en eutopsy

24b. Were eutopsy findings available prior to completion of cause of deeth?

Approximate Interval Between Onset end Death

1 Yes 2 □ No

1 Poyes 2□ No

25. Wes case referred to medical 1 X Yes 2 □ No

28a. Date of Injury (Month, Day Year)

28b. Time of Injury unk P.M 28c. Injury et Work? 1 🗆 Yes

26. Piece of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6X Other (Specity) VEHICLE 28d. Describe how Injury occurred

5 Pending investigation .14.98 2 Accident 6 Could not be determined 3 Suicide 28e 4 Homicide

Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) loskin

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

and 281. Location (Seet end Number or Rural Route Number, City or Town, Stete)

EU

29a. Certifier (Check only one)

27. Manner of Deeth

1 Neturel

plat 1🖵 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner es stated. Medicat Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and images stated.

29b. Signature and ti

29c. License number

29d. Date signed (Month, Dey, Year)

51

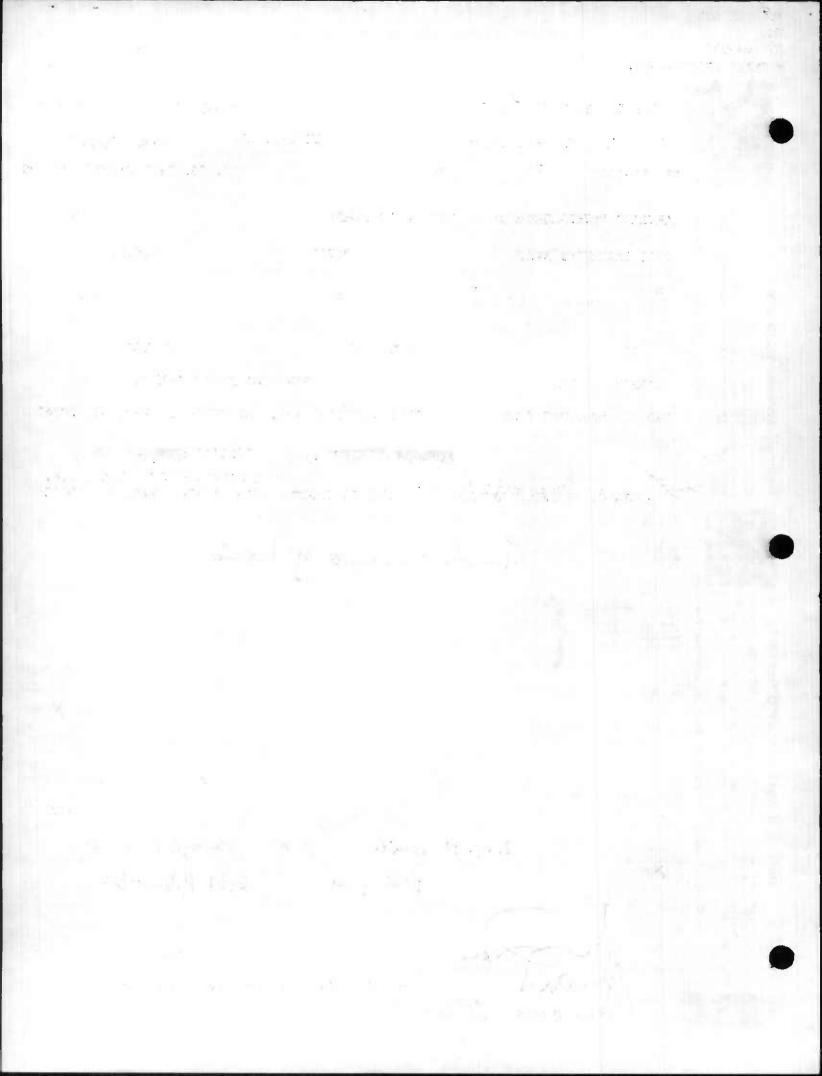
OCME

FEBRUARY 15, 1998

completed cause of death (Item 23e) (Type, Print) 30. Name and ad

111 Penn Street, Baltimore, Maryland 21201

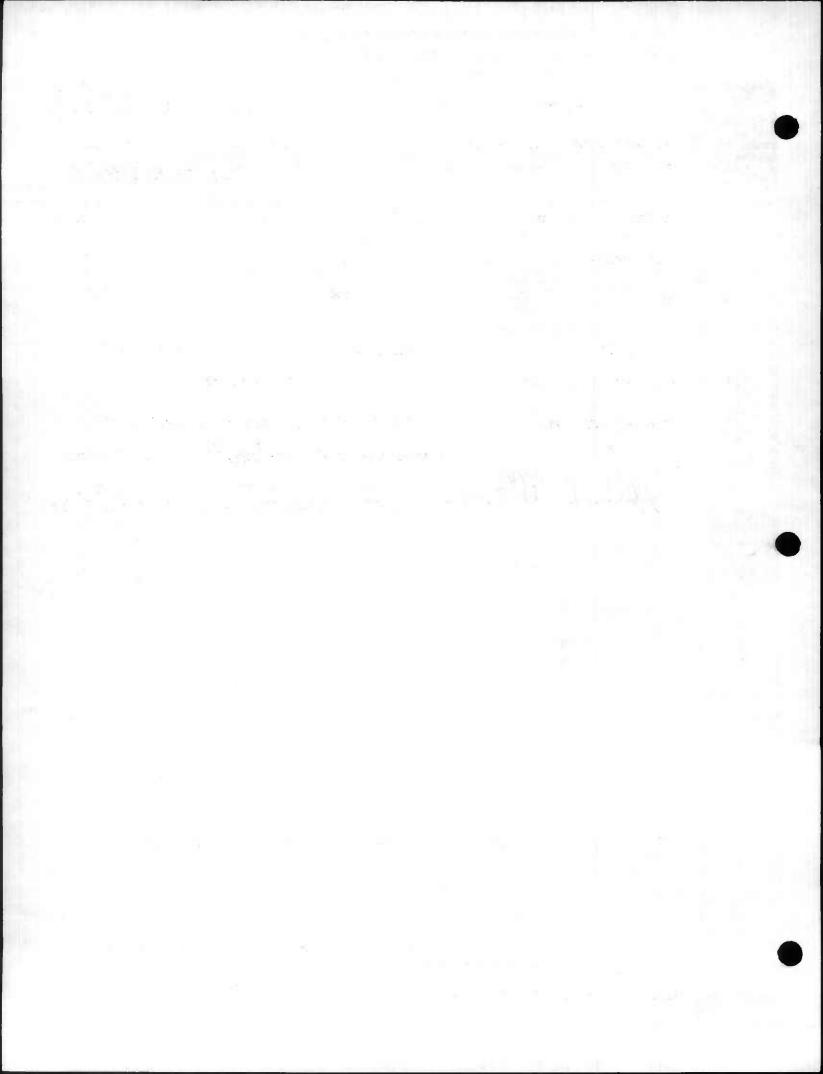
State Registrar 31. Date filed Month Day, Year) FEB 2 0 1998 32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene

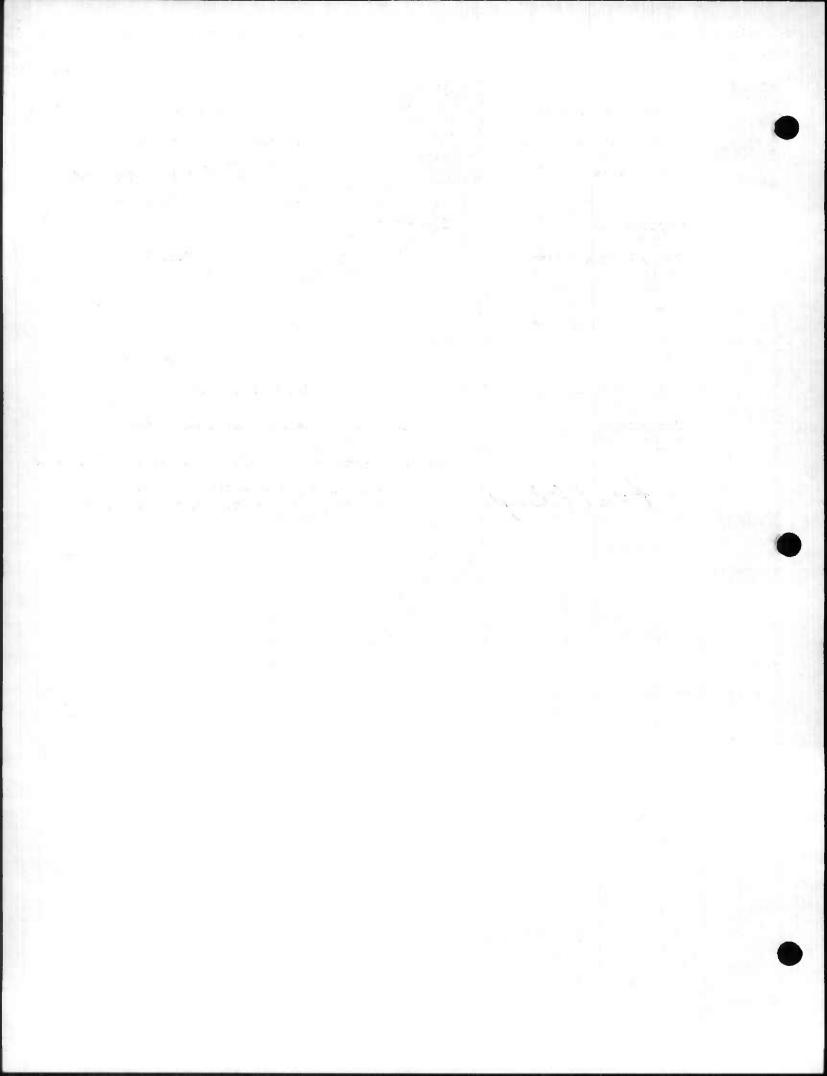
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death **Physician** Month VICTOR ARIEL DUFOUR, SR. February 1:00 AM 12, 1998 /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | 88 | Yrs. | Months | Days | Hours | Min. | March | 26, 1909 710 Heritage Lane, Apt. D Harford 5. Scolel Security Number 6. Sex Birthplece (Stete or Foreign Country) **Funeral** 1 □M 2 □ F 195-05-7273 Director Maryland Usuel Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Maryland Harford Bel Air Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 710 Heritage Lane, Apt. D 21014 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 72 hours after 1 ☐ Navar Married 2 ☐ Married 1X Yes 2 □ No If Yes, Give Year or Detes: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced WII Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within 7: Department of Haelth and Mantel Hygiena. important: It itam 27 is merked other than "nu any injury or other traumetic event, the Mexil space. Elementery/Secondary (0-12) College (1-4or 5+) Machinist Civil Service 11 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) John Francis Dufour Mary Jane Drury 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) John Dufour/Son 14 Sidewell Ct., Baltimore, Maryland 21221 20e. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other placa) Deta 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Ramoval from State Hilltop Service Corp. Towson, Maryland 2-14-98 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Addrass of Facility Howard K. McComas III Funeral Home, P.A. mas 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart fill urf. List only one ceuse on each line. Approximeta intervei Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) e. ASCVD Examiner Due to (or es e consequence of): Examiner physician and s the bunal-transit be axecuted Sequantially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medical The law requires that the death certificate Dua to (or es e consequence of): attending p 98 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown signed b Records, ρλ been si 24b. Were eutopsy tindings aveileble prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performad? page 2 has certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ▼No Division of Vital spital or Attending Physicien: Thours efter death.

neral Director: After this certificate filled in by the funeral director, ps 25. Wes cese reterred to medical examiner?
1 → Yes 2 → No Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
Injury et 28d. Describe how Injury occurred Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of injury (Month, Dey Year) NA 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 1 Naturet 2 Accident 5 Pending NAM 1 ☐ Yes 2 ☐ No NA Invastigation 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide Hospital hours Funeral To the Hosp within 24 hou To the Funer completely fil 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. Medical 2 Medical Examiner: On the besis of examinetion and/or Investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) DME OCME Feb 12th 1998 1081 30. Name and add mose of death (item 23e) (Type, Print) Fulford Aug Rell Mr MD. 21014 410-879-6564 State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otate of h	nai yiai io		tificate of	Death		Reg. No.	06	5589
	Physici		Decedent's Name (First, Middle, La Horace Emil Ed						2. Data of De Month 2-8-1	Day	Yaar	3. Time of Death 11:28 A.M
	/Medi Examir		4a. Facility Name (If not institution, give		r)			4b. City, Town, or Lo			of Death	11:20 A.M
	LAGITIII		27796 Plummers	Lane				Greensbo	ro	Caro	line	
	Funeral Director		5. Social Security Number 6. 5	Sex 7. A	ga (In yrs. ia:	st birthday) Yrs.	If Undar 1 Yaar Months Days	If Undar 24 Hrs.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthpla Country	ce (State or Foreign
٠	D.		213-12-5742 Usual Residence of Decedent 10a. State 10b. County		81	Town or Lo	cation		May 30	1916	Maryl	d. Inside City Limits
	a-f aho	Director	Maryland Carolin	e		eensbo					100	1 ☐ Yes 2 ☑ No
	7 28	ie	10e. Street and Number				10f. Zip Code			10g. Citizen of 1	What Countr	y?
	h wil	al C	27796 Plummers L	ane			21639			U.S.A.		
0	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Heelth and Mentel Hyglene. Itam 27 is merked other than "natural", or items 23s or 28s-f ahow other traumatic avent, its Med cal Examiner must be notified at	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Deceder Armed Forces 1 □ Yes 25 If Yes, Give	?		Vas Dacedant of H Yes, specify Cub	dispanic Orlgin? (Sp an, Maxican, Puarto Specify:	ecify Yes or No Rican, etc.)	14. Rac Blac	e - America ck, White, at	c.
000	iral.	d by	3€Widowed 4 □ Divorced	Year or Dates	:		2000	ореспу.		Specify	Wh	ite
21215-0020	2 should be filed within 72 hours after and Mentel Hyglene. Is marked other than "natural", or a surnatic avent, the Med call Evant.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade com <i>pleted)</i> College (1-4o		(Give I	ent's Usual Occup kind of work done OO NOT use retire	during most of work	ing	16b. Kind of B	usiness/indu	stry
	ygie ygie rt,		ll-grad			farı	ner				n-dair	У
anc	be fill d out	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			18)	
3	should be fand Mentel Is marked of umatic ave	2	Kellor Edwards					Mattie 1				
Maryland	12 sh h and ia m		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street	and Number or Run	al Route Numb	er, City or Town,	State, Zip C	Code)
	Heelth Barn 27 i		Kathy Bunty 20a. Method of Disposition		20h Bla		Box 12.	l Allen,				
20	it of h		1 St Burial 2 □ Cremation 3 □		000	netery, crem	atory or othar pla		Date	20c. Location -	City or Tow	n, State
Η̈́	tmer tant:		4 □ Donation 5 □ Other (Specif		Gre		co Cemet		2/11	Greensl	oro,	Maryland
Baltimore,	permit. Pages 1 and Department of Heelth important: if Itam 27 any injury or other to 90.08.		21. Signature of uneral Sarvice Lice	lend		F		ess of Facility Helfenbe: 160 Green:				20
	Physician /Medicai Examiner	16	23a. Part1. Enter tha disease, or com shock, or heart failure. List only Immediate Cause (Final disaase or condition resulting in death)		speet		neer-	Untrown			C	Approximata Interval Between Onset and Death 3 Months
Box 68760,	eath certificete be executed attending physician and for use es the burlai-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		as a consequ						
	the att	sicle	Part II. Other signfficant conditions of	contributing to death	but not result	ing In the un	derlying cause giv	ven in Part I.	23b. Did	tobacco use co	ntributa to t	he cause of death?
, P.O	es that the de igned by the be detached	by Physiclan/N							10	Yes 2□No	3 Proba	bly 47 Unknown
Records,	aw requir as been s 2 should	Completed t	Avenia, Co Hydro cephali	us Lyi	nghan	na				an autopsy ormed?	avail	e autopsy findings able prior to plation of cause eath?
F	The Page	S							101	Yes 2 No	10	Yes 20 No
Vit.	ician: The licetanicetanicetor, page	Be	25. Was case referred to medical examinar?	112-1			Tax	26. Place of Deat	h (Check only o	ne)		
on of Vital	G S	tlon: To	1 Yes 2 No 27. Manper of Death 1 Natural 5 Pending	28a. Date of in (Month, D	ient 2 El iury a <i>y Year)</i> 2	R/Outpatient 8b. Time of Injury	28c. Inju	4 U Nursing Ho		dence 8 Oth how injury occur		
Division	if or Attending Ph efter deeth. Director: After th d in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homloide determined	e 28e. Place of Ir	njury - At hom etc. <i>(Specity)</i>	e, farm, stre	et, factory, offica		28f. Location (: City or Tox	Street and Numb wn, State)	er or Rural I	Poute Number,
	To the Hospital or A within 24 hours efter To the Funeral Dirac completely filled in b	Medical C	29a. Certifier (Check only one) Certifying Ph	iyalclan: To the bes niner: On the basis tand manner s	of examinatio	edge, death n and/or inv	occurred at the tirestigation, in my c	me, date and placa, opinion, death occurr	and due to the ed at the time,	cause(s) and ma date and place,	anner as stat and due to t	ted. he cause(s)
	o the	Me	29b. Signature and Hitle Orgogetier	And mained s			29c. Licens	se number		29d. Data signe	d (Month. De	ay, Year)
	F ≯ F ŏ) (Mtx	150	M			47492		2/10	98	
			30. Name and address of person who	completed cause of	death (Item 2	(Type, F		2 Gold	sbaro 1	mn a	14.32	
	Sta Registr		31. Date filed (Month, Day, Yaar) 98		trar's Signatur		dell		,			



	Please	Type or P	rint In Bl	lack In	delible	lnk.	. Assuı	re A	II Copies	s Are	Legi	ble.	
		State of	Maryland		artment rtificate			nd M	/lental Hy	/giene	AB	0	6590
1. Decedent's Na	ıma (First, Middla, Las	(St)							2. Data of De	eath			3. Time of Death
GRACE E	CLIZABETH E	EYLER							Month PERRUAL	RY Da	15	Yaar 199	84:20 PM
	(If not institution, give		ber)				4b. City, Tow	m, or L	ocation of Deat	th 4c	c. County	y of Deat	h
Carrol1	County Go	eneral H	ospital				Westr	min	ster		Car	roll	L
5. Social Security			. Aga (In yrs. la:	st birthday)	If Undar 1			24 Hrs. Min.	8. Data of Bi	irth Year	1	9. Birt	hplaca (Stata or Foraign
212-26-0	670	1□M 2)②F	6	7 Yrs.	Months	Days	Hours	IVIIII.	March	14,1	930		ryland
Usual Rasidance	7												
10a. Stata	10b. County			Town or Lo									10d. Insida City Limits
MD	Carroll	1	W	Testmin	nster								1 Yas 2000
10e. Street and No	umber				10f. ZIp C	Coda				10g. Ci	itizan of V	What Co	untry?
26 Sulli	van Road				21	157	1			U	nite	ed St	tates
11. Marital Status	1	12. Was Deced	dant Evar in U,S.	. 13.1	Was Daceda	int of H	lispanic Origi an, Maxicen,	in? (Sp	pecify Yas or No	0-		ca - Ama	rican Indian,
	arried 2 Married	1 Tas 2 If Yas, Giva Yaar or Date	No No		1 ☐ Yes 2			T during	/ House, wive,		Specify	4	White
(Sn	15. Decedant's Ed	ducation		16a. Decer	dant's Usual	Occup	pation	of worl	kina	16b. k	Kind of B	usinass/	Industry
Elementary/Sec		Collega (1-4	4or 5+)	_	DO NOT usa	retired	during most of	Or Wor.	tung	In	stit	cutio	on
	a (First, Middla, Last))			JUK		18. Mothar	r's Nam	na (First, Middle				
	Joe Strit								de Mae				
	Name/Ralationship (19b. Mailir	ng Address ((Street			rai Routa Numb			Stata, 2	Zip Coda)
Frank Ey	ler/son			2425	Benso	on F	₹d. Wes	stm	inster,	MD	2115	58	1-3
20a. Mathod of Di	-		cen	ace of Dispo matary, cran	osition (Name matory or oth Cremat	a of har place	ca)		Date	20c. L		- City or	Town, Stata
21. Signatura of	Funaral Sarvice Licen	1500 P. Mage	· rs	M	yers F	une	eral Hoer, MD	ome,	, 91 Wi 157	llis	Str	reet	
23a. Part1. Entar shock, or he	r tha disaasa, or comp eart failure. List only												Approximate Interval Batween Onset and Death
Immediata Causa disaase or condit rasulting in daath	tion	a. Aa	LTE	PhL	Mor	VA	RY	E	MBOL	151	4		2 WEEKS
		L	Dua to (or a	as a conseq	quance of):								
Sequantially list of any, laading to causa. Entar Uno Cause (Disease of	immadiata	b	Dua to (or a	as a conseq	quanca of):								
that initiated avan	nts	С.	Dua to (or a	as a consaq	juance of):								
		d											
Part II. Other sign	nificant conditions o	ontributing to dea	th but not rasult	ting in tha ur	ndarlying car	usa giv	an In Part I.			d tobacc			n to the cause of death? Probably 4 Tonknown
									24a. Wa per	is an auto formed?	opsy		Wara autopsy findings availabla prior to complation of causa of daath?
									1□	Yas 2	2 12 No		1□Yas 2☑No

28. Placa of Daath (Check only one)

28c. Injury at Work?

1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

1 ☐ Yas 2 ☐ No

Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify)

28d. Dascribe how Injury occurred

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signad (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, the Medical Examinet must be need at once.

Baltimore, Maryland 21215-0020

Funeral Director

Completed by

Be

been signed by the attending physician end should be datached for use as the buriel-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2:

Physician/Medical Examiner Part II. Other Be Completed by 25. Was casa rafarrad to madical axaminar?

1 Yas 2 No Certification: To 27. Manger of Daath

edical

Division of Vital Records, P.O. Box 68760,

State Registrar 31. Data filad (Month, Day, Year)

29b. Signatura and titla of cartifiar

FEB 1 7 1998

5 Pending invastigation

6 Could not be datarmined

Mac Low Ma D (4 6 9 6 2 FEBRUARY 15 1998)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Memorial Ave., Westminster, MD 21157

M. SIHIRA 21, N.D. PHY SIGAN. CANNOW COWTY GENERAL HOSDITAL MD 21157 32. Registrar's Signatura

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28a. Data of Injury (Month, Day Year)

1 Natural

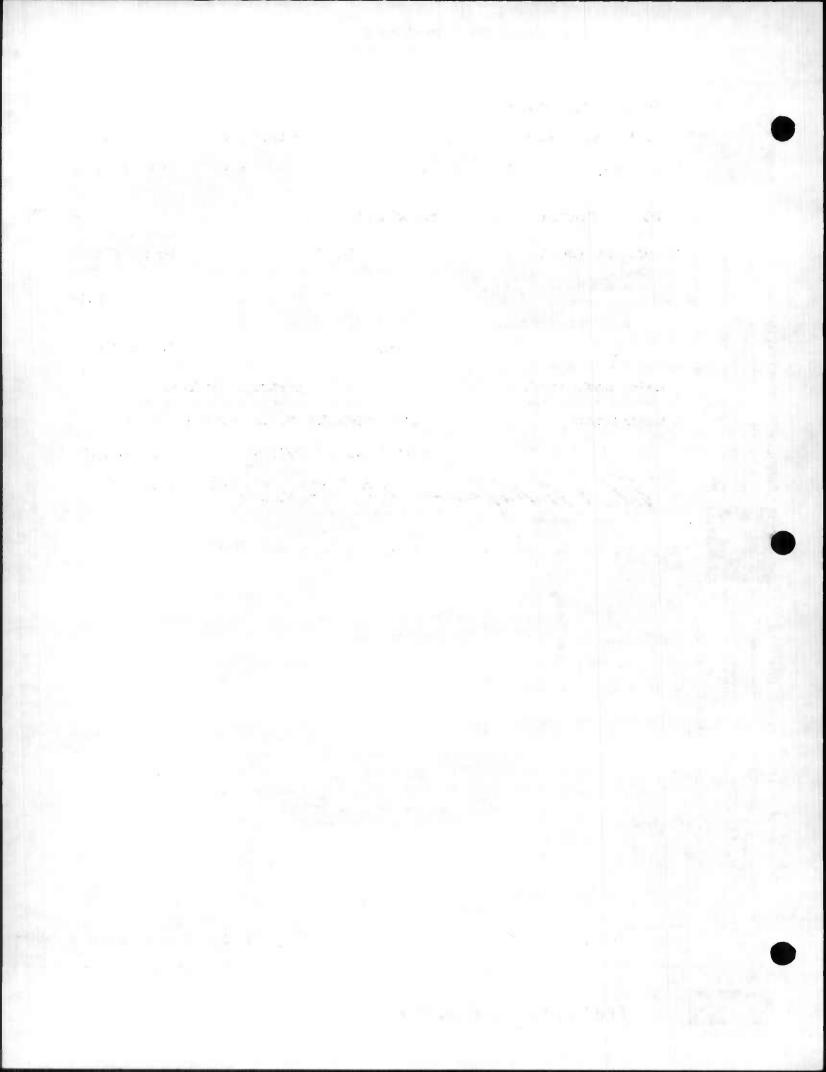
2 Accidant

3 Suicida

29a. Certifiar

4 Homicida

(Check only one)



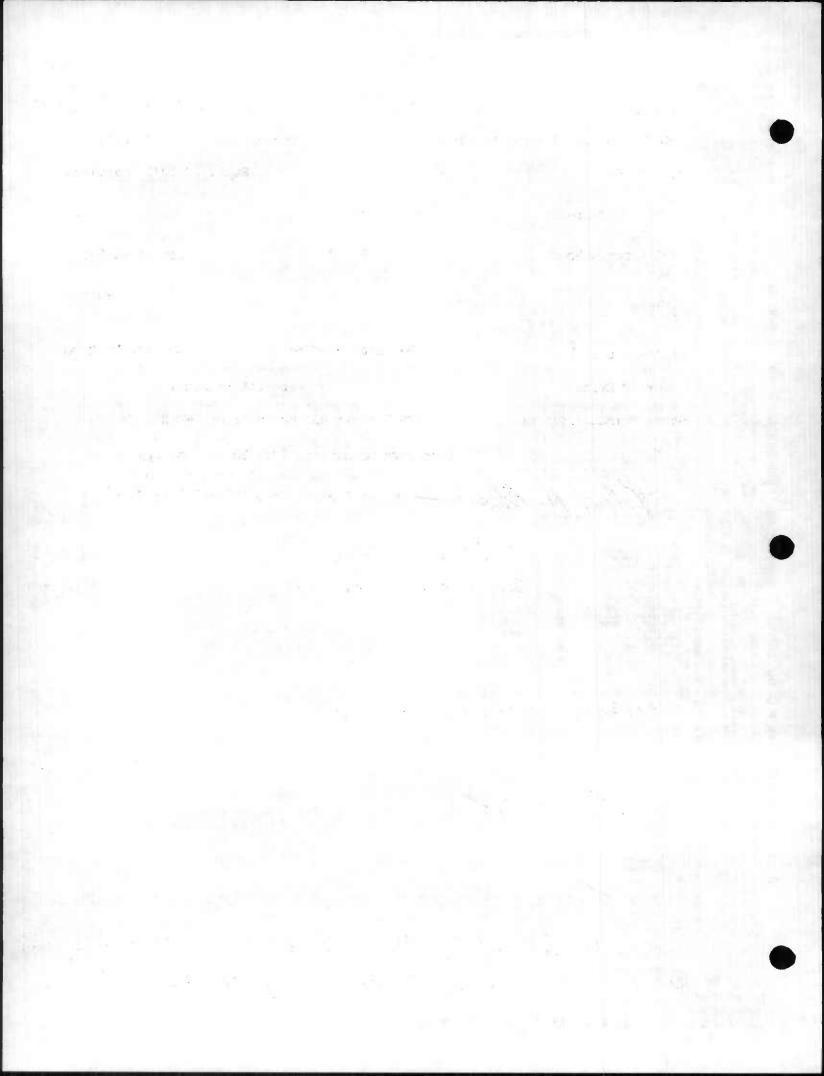
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Month Day 16,1998
cation of Death 4c. County of Death **Physician** EYLER SITIRLEY DELORES 20001 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number, Examiner Carroll County General Hospital Westminster Carroll 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 58 Yrs. Months Days Hours Min. Sept. 12,1939 5. Social Sacurity Number Birthplaca (Stata or Foraign Country) 6. Sax **Funeral** 1 M 3 F 213-44-9497 Maryland Director Usual Rasidence of Decedant with the Manylend 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryler nent of Haaith end Mental Hygiene.

Int: If item 27 is marked other then "natural", or items 23a or 28a-1 show ury or other traumatic event, the Med cal Examinat must be notified. MD Carroll Westminster 11 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 178 Lincoln Road 21157 United States Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑No If Yas, Giva Yaar or Datas: 14. Race - Amaricen Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) Elementary/Secondery (0-12) College (1-4or 5+) Material Handler Shelter Workshop 14(Special ed.) 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Gerald Eyler Margaret Frizzell 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Hazel Frizzell/sister 178 Lincoln Rd. Westminster, MD 21157 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Deer Park Methodist 2/19/98 Smallwood, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 91 Willis Street Myers Funeral Home Westminster, MD 21157 23a. Pa/1. Entar the disease, or complications to caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximete Interval Batween Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical Examiner Physician/Medical Examiner physician and the burief-trensit The law requires that the deeth certificate be axecuted Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that Initiated avants rasulting in daeth) Last P.O. Box 68760. Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown VASCULAR ACCIDENT Division of Vital Records, 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy complation of ceusa of death? certificate hes b director, page 2 s 1 Yas 2 No 1 Yas 2PINO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was cesa rafarred to medical axaminar?
1 Yas 2 No 26. Piece of Deeth (Check only ona) Be To Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1/ Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manwer of Death 28c. Injury et Work? 28d. Dascribe how injury occurred 28b. Tima of Certification: Naturel 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

| Medical Examinar: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Cartifiar Medical (Check only one) 29d. Data signed (Month, Day, Yaar) 29b. Signature and titla of certifian 29c. Licansa number 028221 30. Nama and address of person who completed course of death (116m 23a) (Type, Print) 200 MemoriaL AVE., Westminster, MD, 21157 CANDOLL COUNTY CENERAL SYTALIAFEDER MO 31. Data filad (Month, Day, Year) 32. Registrar's Signatura Jahr Davidson Re Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item #9, Per F.D. State of Maryland / Department of Health and Mental Hygiene | | 2/13/98, Carroll County, wjl Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** L. GLICK 10 ALICE FCL 12 /Medical 4a. Facility Nema (If not institution, give street end number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1□M 2₩F Months Deys 83 **Director** 579 22 1575 30, 1914 Tenn Usual Rasidence of Dacedant MARYLAND 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Md. Howard Director 1 ☐ Yas 2 No Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21771 U.S.A. 4104 Baltimore National Pike 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Naver Merried 2 Marriad 1 ☐ Yas 2 ☐ No by Specity: 3℃ Widowad 4 Divorced white Completed 15. Dacedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 9 Homemaker Domestic 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Be Charles Morningstar Emma unknown 19a. fnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Carol Hawse (daughter) 11838 Lime Plant Rd. New Market MD 21774 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Carroll Cremation 2/13/9B Hampstead MD 21. Signatura of Funeral Sarvice Licansaa 22. Nema end Addrass of Facility Haight Funeral Home Parge Harglet Herbert P.O. Box 195 SYkesville MD 21784 23a. Pert1. Entar tha disaasa, or complications that caused the deeth. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one cause on each line. Approximata Onsat and Death Physiclan /Medical Immediata Causa (Final disaasa or condition rasulting in daath) **Examiner** Examiner ERITONI The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, laading to immedieta causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last and Division of Vital Records, P.O. Box 68760, ed by the attending physician datached for use as the burie Due to (or as e consequança of): Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? this certificate has been signed by ral director, page 2 should be datac 1 Yes 2 No 3 Probably 4 Onknown Completed by 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of cause of daath? 1 Yas 2 No 1 ☐ Yas 2 No Hospital or Attending Physician: Be 25. Was casa rafarrad to medical 26. Placa of Daath (Check only one) Hospital: 12 ER/Outpetient 3 DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 2 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred After 1 Natural 5 Pending ours after death. 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not be datamined 3 Sulcida 28a. Plece of Injury - At homa, farm, streat, fectory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida To the Hospital or within 24 hours at To the Funeral D completely filled i Medicai 29a. Cartifian 1 🔂 Certifying Phyaician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as statad. 2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signeture and title of certifier 29c. Licansa number 29d. Data signed (Month, Dey, Year) D19510 MID: 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) A.D. VAKARUNI, M.D. HICKORYRIDGE ROAD, COLUMBIA, MD 21044 Year) 32 Registrar's Signatura

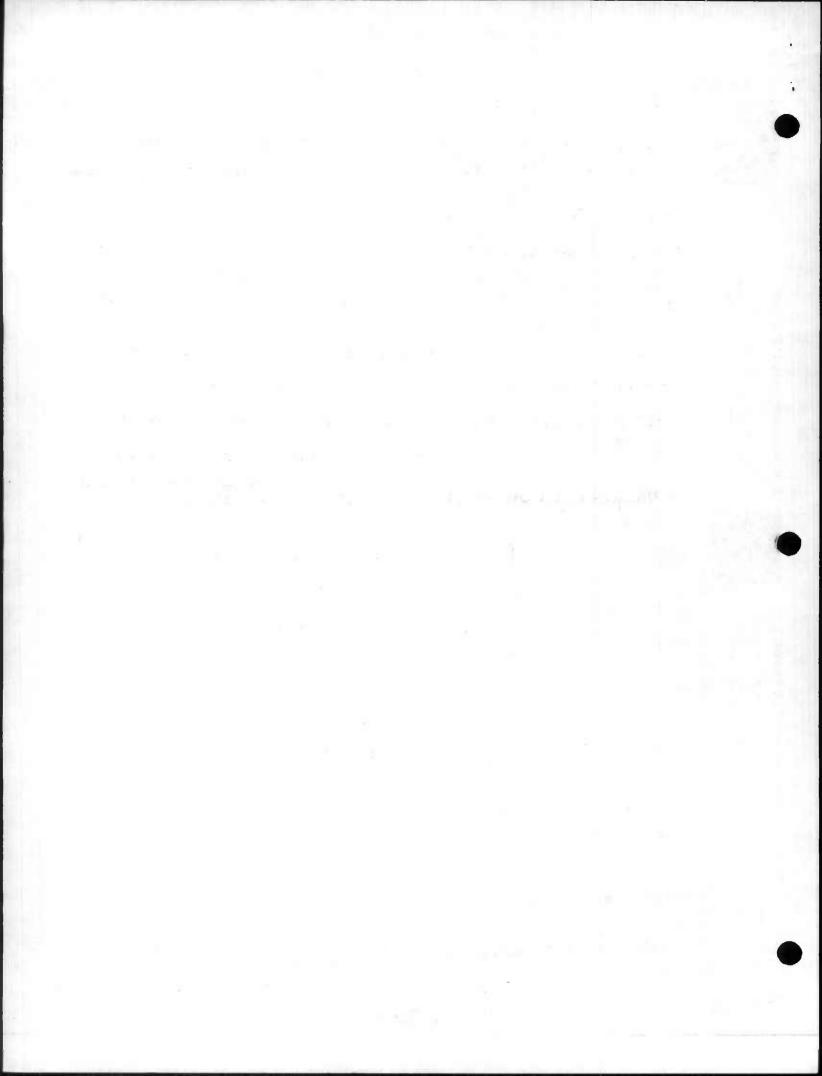
John Shudger Radall

State Registrar

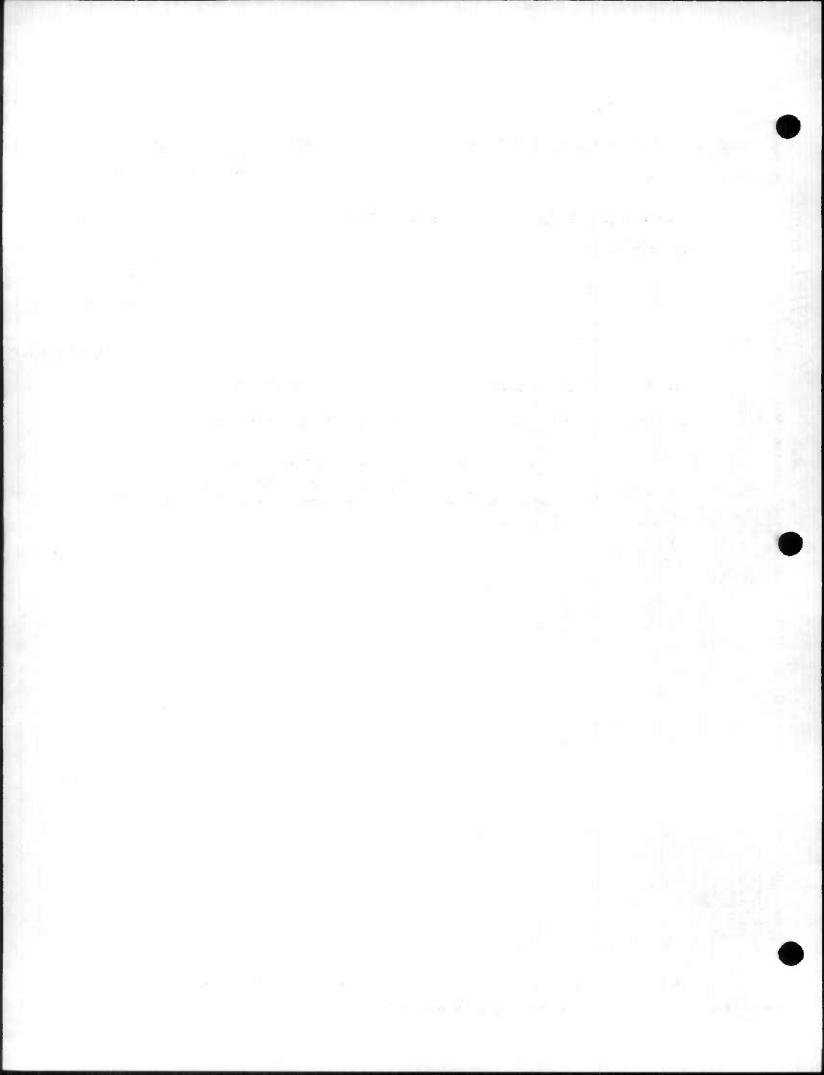
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			State of Maryland / Department of F Certificate of	dealth and M Death		giene 9 8 Reg. No.	U	6593	
	Physici /Medi		Decedant's Nama (First, Middle, Last) EVA MAE HOLSTON		2. Date of Dea Month Feb	Day	Yaar 998	3. Tima of Death 6:47P	
	Examir Funeral		The Memorial Hospital 5. Social Security Number 6. Sax 7. Aga (In yrs. lest birthday) If Undar 1 Yaar	Easton If Under 24 Hrs. Hours Min.		Talbo	ot	aca (Stata or Foraign	
	Director		213-20-7096 / Yrs. // Yrs. // Usual Rasidanca of Dacadent	nours Min.	8. Data of Birt (Month, Da NOV • 2	5,1926		aca (Stata or Foraign try) LAND	Y
	h the Maryland r 28a-f show	ctor	10a. Stata 10b. County 10c. City, Town or Location MARYLAND DORCHESTER EAST NEW MARKET				10	od. Insida City Limits 1 ☑ Yes 2 ☐ No	
	death with the Maryland rms 23a or 28a-f show rms be notified at	Funeral Director	10e. Streat end Number 10f. Zip Coda 16 MAIN STREET 21631			10g. Citizen of W USA	hat Coun	try?	
5-0020	ours after dea al', or items Examiner m	by	1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	tispanic Origin? (Spi an, Mexican, Puarto Specify:	acify Yes or No- Rican, atc.)		, Whita, a	atc.	
0-61212	d within 72 hours after des giene. r than "natural", or items the Medical Examinet in	Completed	15. Dacadant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) 11 15a. Decedent's Usual Occup (Give kind of work dona life. DO NOT use ratired) ELDERCARE	pation during most of works d)		16b. Kind of Bus			
yland,	tal Hyg d othe event,	To Be C	17. Fether's Nama (First, Middla, Last) GEORGE WASHINGTON COLHOUER	18. Mothar's Name	a (First, Middla,	Maidan Sumama			
, mary	is 1 and 2 should of Health and Man Itam 27 is marks other traumatic		19a. Informant's Name/Relationship (Typa, Print) WILLIAM H. HOLSTON/HUSBAND P. O. BOX 27					Coda)	
pairimore	Pages 1 enent of Henners of Henne		20a. Mathod of Disposition 1 🕅 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 🕭 □ Other (Spacify) 20b. Placa of Disposition (Nama of camatary, cramatory or other place of Disposition (Nama of camatary, cramatory) EAST NEW MARKET C		Data 2/21	20c. Location - C			
Dail	permit. Pages Decartment of Important: If Its any Injury or o		21. Signature of Fureral Service Licertises 22. Nama and Addra ZELLER FUN 106 MAIN S	ss of Facility ERAL HOME	, P. O.	BOX 207	,		
	Physician	(23a Part Enter the disease, or complications that diused the death. Do not anter the mode of dyir shock, or heart failure. List only one cause op each line.	ng, such as cardiac o				Approximata Intarval Betwaan Onsat and Death	
	/Medical Examiner		Immediata Causa (Final disaasa or condition resulting in death) Dua to (or as a consequence of):	failure				6 days	
	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate					o days	
ox peron,	es that the death certificate be executed gned by the ettending physician and be deteched for use as the burial-transit	edical	Sequantially list conditions, if any, leading to Immadiate causa. Entar Undarlying Causa (Disaasa or Injury thet initiated avants rasulting In death) Last Dua to (or as a consequence of): Dua to (or as a consequence of):						_
0	the death or by the ettenion	Physician/M	Pert It. Other algnificant conditions contributing to death but not resulting in the underlying causa giv	an In Part I.	23b. Did t	obacco usa conf	tribute to	the cause of death?	
, L	es that the igned by be detected	by	chronic obstructive pulmonary discuse		1 🗆 '	res 200 No	3 Prob	ably 4 🗆 Unknown)
nicoar	The law requires that ate has been signed b paga 2 should be delt	Completed	Hyper tension			an autopsy rmed?	eva	ra autopsy findings illable prior to applation of cause leath?	
	certificate rector, pag	Be Co	25. Was case referred to medical examinar?	26. Place of Death	1 (Check only o		1 🗀	Yas 200 No	
DIVISION OF	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has complately filled in by the funeral director, paga 2	ertification: To	Hospital: 1 Impatiant 2 ER/Outpatient 3 DOA Other	y at k? Yas 2 No	28d. Describe h	lanca 8 ①Othai now injury occurre Straat and Numba n, Stata)	d		_
	Hospita 24 hours Funeral iataly fille	edicai C	29a. Cartifiar (Check only one) 12 Cartifying Physician: To the bast of my knowledge, death occurred at the tire and manner stated.	ne, date and placa, pinion, daath occurr	and dua to tha ded at tha tima, d	causa(s) and man data and placa, ar	nar as stand due to	ated. the cause(s)	
,	To the within To the comp	Me	29b. Signeture and title of certifier 29c. Licans 23c. Licans	e number		29d. Dete signed	(Month, L	Dey, Year)	
			30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) DAVID G. OLIVER, M.D., 503 DUTCHMAN'S LANE, E	EASTON, MI	21601				
	Sta Registr		31. Data filad (Month, Day, Year) FEB 2 0 1998 32. Redistrar's Gignature						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #10c, Per F.D. 2/17/98, Carroll County, wil Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month 4a. Facility Name (If not institution, give street end number) February 15 1998
4b. City, Town, or Location of Death 4c. County of Death /Medical 8:00 am Examiner 2300 Pin Oak Drive Finksburg Cannoll if Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Social Security Number if Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) 9. Birthpiece (State or Foreign Country) **Funeral** 1□M 2**X**F 566-44-9490 62 Yrs. Director 1935 California Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment than the mother as 10a. State 10b County 10c. City, Town or Location 10d. inside City Limits Cannoll Finkabung, 1 ☐ Yes 2 No Funeral Director Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2300 Pin Oak Drive 21048 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Be Completed by Specify: 3 Widowed 4 Divorced white Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) wrote instruction manuels Social Security Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John Hendy Gladys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley A. Gasser 5 Harmony Mill Court, Baltimore, MD 21228 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 2/17/98 Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State Carroll Cremations Inc. 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 22. Name and Address of Facility
Pritts Funeral Home & Chapel 21. Signeture of Funeral Service Licensee **Xathurine Pritto - Sweitzer 4/12 Washington Rd., Westminster, MD

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximate Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificete be axecuted use es the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760. Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Q 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy performed? this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by tha funaral director; I 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

Records, of Vital Division

Registrar

Medicai

31. Date filed (Month, Day, Year)

29b. Signature and title of purifier

(Check only one)

Belvedere Ave #206 32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jaka Davelson Radall

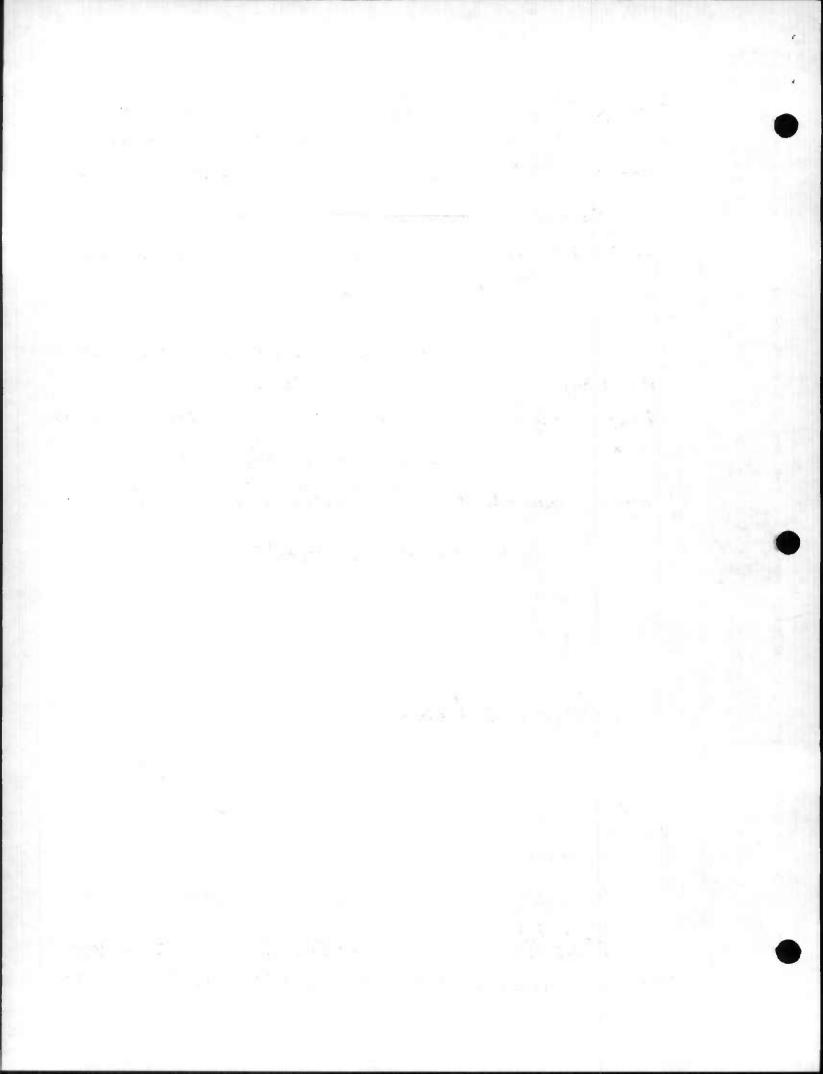
29c. License number

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Fouad Abbas, M.D.

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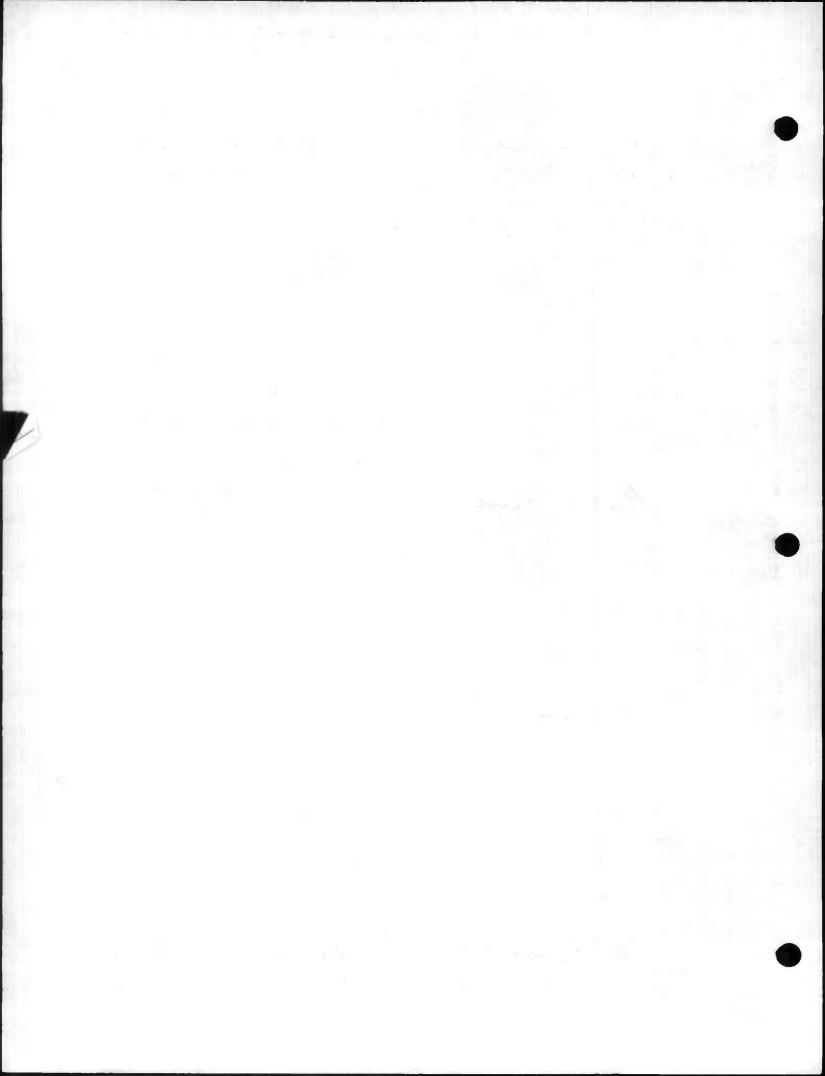
29d. Date signed (Month, Dey, Yeer)



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DIVISION OF VITAL RECORDS,	T.
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	CONTRACTOR ATTENDIAN DUNCHARL The last consistent the deadle confidence he consistent at he

	FOR 1 - STATE REGISTRAR	STATE OF N					EALTH AND DEATH	MEN	TAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Lest)				IOAIL	- 0.	DEATH	2. D/	TE OF DEATH			3. TIME OF DEATH
	Hazel Carolin	ne Hale	v					Fe	bruary by	9 1	1998	6:30 p.m.m
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. In	ast birthday)	IF UNDER		IF UNDER 24 HRS.	7. DA	TE OF BIRTH		8. BIRTNE	PLACE (State or Foreign
	216-22-9776	1 🗆 M 2 💢 F	85	YRS.	MONTHS	DAY\$	HOURS MIN.	Mä	r. Day Year) 1	912	Ma	ryland
NO.	9e. FACILITY NAME (If not institution, give states 1937 Old Taneyto				96. CITY		RLOCATION OF D Stminste			111111111111111111111111111111111111111	arrol	
ן כ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	v		I 40 . 047								
DIRECTOR	Maryland Car	rroll		10c, CH	Wes		nster					10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	1937 Old Taneyto	own Rd.				101	ZIP COOE	115	8	10g. CITI		J.S.A.
B	11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2 X			it yes, spe	ENDENT OF HISPA Holfy Cuben, Mexico 2 X NO Specia	en, Puer		or No-	14. RACE Black, Specifi	- American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12)		(DECEDENT'S Give kind of te. Do NOT u	work done se retired.)	during mo		Т	16b. KIND OF BUS			
M M	8			home	makeı				own	home		
ទូ	17. FATHER'S NAME (First, Middle, Last)								st, Middle, Maiden		1	11 -
M M	Charles Flicki	nger							Ellen			ite
2	190. INFORMANT'S NAME (Type/Print) Earl R. Haley/ N	nusband	1				nd Number or Rural Eytown R					ID 21158
	20e. METHOD OF OISPOSITION 1 🔀 Burtial 2 🗆 Cremation 3 🗆 Remit 4 🗎 Donetion 8 🗀 Other (Specify)	oval from State		EANODATE			ardens	4		cation – nksbu		
	21. SHEHATURE OF FUNCIONAL SERVICE LIC	CENSEE	lands	e-	22.	NAME AN	Broadwa		Hartzl	er Fu	ınera	11 Home ID 21791
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	. Ma 200	(OR AS A CONSI	Info EQUENCE O EQUENCE O	rct 10 19: 13510 19:	ń	de of dylng, suc	ch es c	ardiac or reepi	ratory arr	rest,	Approximate Interval Between Onset and Death Minufrs
CERT	that initiated events resulting in death) LAST d.											
IN: MEDICAL	DID TOBACCO USE CONT	en	USE OF DE	ATH Y	ES 🔲 I	NO 🔽			. 24a. WAS AN PERFOR	IMED?		WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PL/	ACE OF DEA	OTHE							
PHYS	1 VES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending	1 tnpatient 2 0	INJURY	28b. T/N	4 🗆 Nur	28c. INJ WO	RK?	_	Other (Specify) DESCRIBE NOW II	NJURY OC	CURED	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide determined		M 1 YES 2 NO LACE OF INJURY — At home, ferm, streel, fectory, office ulfding, etc. (Specify)						LOCATION (Street I City or Town, Stete)	and Number	or Rural R	oute Number,
MPLET	29a. CERTIFIER (Check only	ICIAN: To the best of	my knowledge,	death occur	red at the t	lme, date	and place, end du	e lo lhe	ceuse(e) end mer	nner ee atal	ted.	
COM	one) 2 MEDICAL EXAMINE	R: On the besis of e	xamination end/o	r investigati	on, in my o	pinion, d	eath occured at the	e time, o	date end place, en	d due to th	ne couse(o)	end manner ee stated.
O BE C	290. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month).											
ĭ	30. NAME AND ADDRESS OF PERSON WN Herbert P. Hevidev 31. DATE FILED (Month, Day, Year) FEB 13 1	32. REGISTA	SE OF DEATH (IT	37 UI	vien P	hide	o Rd P.	0.B	ox 190 A	lew L	inds	or M021776

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6		1. Decedent's Name (First, Midd	lle, Last)			1 F					2. Date of D		Dey	Yeer	3. Time o	f Death
Physic /Medi		William	R.		SACU.	SON					Feb	10	1998		6:00	pm
Exami		4a. Facility Neme (If not institution	on, give street	and numl	ber)			4	b. City, To	wn, or Lo	ocation of Dea	ith	4c. County	of Deeth		
		Corsica Hills	Nursin	g Hor	ne				Cent					Anne		
Funeral		5. Sociei Security Number	6. Sex 1 ☑ M 2			. last birthday)	If Under	1 Yeer Deys	If Under a	24 Hrs. Min.	8. Dete of B (Month, L	irth Day, Ye	ar)	9. Birthpla Country	ce (State	or Foreig
Director		215-36-1651	T CALIVI 2		78	Yrs.					April 6 1919 Maryland					
and *	1	Usuai Residence of Decedent 10e. Stete 10b. County	,		10c. Ci	ity, Town or Lo	cation							100	d. Inside C	Sity Limit
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ars al	by	3 ☑ Widowed 4 ☐ Divorced	· If	Yes, Give		1	1 🗆 Yes	251 No	Specify:				Specif	y: Wh	ite	
be filed within 72 hours after death with the Meryland nat Hyglene. I do other than "naturel", or items 23a or 28a-f show event, the Medical Examinat must be notified at	Pe	15. Deceder	nt's Education			16e. Deced	lent's Usu	ai Occup	etion			16b	Kind of B	usiness/Indu	stry	
hin 7	Completed	(Specify only higher Elementary/Secondery (0-12)	-	pleted) bliege (1-4	for 54)	(Give	kind of wo DO NOT u	ork done d se retired	during most d)	of work	ing					
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uld b Menta rked rked	To	Courtland Jack	son						Eth	el (uiller	Ja	cksor	1		
12 should be filed withling and Mental Hygiene. 1s marked other than raumatic event, the M	1	19e. Informent's Neme/Relations	ship <i>(Type, Pr</i>	int)		19b. Meilin	ng Address	S (Street	and Numbe	or Rur	al Route Num	ber, Ci	y or Town,	State, Zip C	code)	
s 1 and 2 should if Health and Mer item 27 Is marke other traumatic		Leslie A. LePo	re						kline	Roa	d Hen	der	son	MD 2	1640	
		20e. Method of Disposition 1 Buriel 2 □ Cremetion	3 Demov	ai from St		Place of Dispo cemetery, cren	sition (Na natory or o	me of other plac	ce)	1	Date	20c	Location -	- City or Tow	n, State	
Pages nent of I ant: If ite ury or of		4 Donetion 5 Other (S		61 II OIII 31	010	Greens	sboro	Cem	etery		2/13	Gr	eensb	oro,	Mary1	Land
permit. Page Department of Important: if eny injury or once.		21. Signeture of Funeral Servica	Licansee	276					ss of Fecilit	-						
8 G E 5 8		Med	OFE		1	F	leeg1	e &	Helfe	nbei	n Fune	ral	Hon	ne, P.	Α.	
		23a. Part1. Enter the disease, o shock, or heert feilure. List	r complication t only one cau	s that cau	used the dee ch line.									1	Approxime	
Physician		Victoria de la compansión de la compansi													Onset end	Death
/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	θ.			WI	_							i	1 hr	
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cete be executed oblysician end the buriai-transit	dical	cause. Enter Underlying Cause (Disease or Injury thet Initiated events										i				
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es that the death certific gned by the attending p be deteched for use es i	N	d														
The law requires that the death certificete be executed to be been signed by the attending physician end page 2 should be deteched for use as the burial-transit	ciar	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.														
y the	Physician/M			ng to deal	th but not res	sulting in the ur	nderlying o	ause giv	en in Pert I.					entribute to t		
that hed b		Revol Fail	سف								1	Yes	25 No	3 Probe	bly 4	Unkn
uires sign	d by										24a. We	s en ei	ıtopsv	24b. Wen	e autopsy	finding
v require been signature	Completed										per	formed	7	com	eble prior pletion of	to
Physician: The law this certificate hes rai director, page 2	mp	2.0											. 6		eth?	
		OF Was soon referred to reading] Yes	2 200	1 🗆	Yes 2L	No
Physician: r this certific rai director,	o Be	25. Wes case referred to medica examiner? 1 Yes 2 No	Hospita	il:		1 mp/p		Oth	or.		h (Check only		a Clau			
r this	: To	1 Yes 2 No	288	1 ☐ Inp	njury Day Yea <i>r)</i>	28b. Time of		28c. Injun Wor	Nu Nu	irsing Ho	me 5 Re 28d. Describe					
Attending or death. ector: Aftel by the fune	tion	Naturei 5 Pendii 2 Accident investi		(Month,	Day Year)	Injury	М		k? Yes 2⊡!	No						
Attendi r death ctor: A	fica	3 ☐ Suicide 6 ☐ Could	not be	. Plece of	f Injury - At h	ome, ferm, str	eet, fector	y, offica			28f. Location			ber or Rural i	Poute Nur	n <i>ber</i> ,
X # = E	Certification:	4 Homicide		building	, etc. (Speci	ty)					City or T	own, Si	a(0)			
Pours Peral Ville		29a. Certifier 1 DaCertifyir	ng Physician:	To the be	est of my kno	owledge, death	occurred	et the tin	ne, date en	d place,	and due to th	e cause	e(s) end m	enner es ste	ted.	
Fu Fu	edical	(Check only 2 Medical one)	Examiner: O	n the basi nd manne	is of examina r stated.	ation end/or Inv	estigation	, in my o	pinion, deel	th occur	red at the time	e, date	and piece,	end due to t	he cause(s)
2 6 9 %	29b. Signeture and title of certifier 29c. License number 29d. Date signed (I														ay, Year)	
To the Hospital within 24 hours a To the Funeral I completely filled								1 -	20 1 3	> (2/1	100		
To the Within 2 To the comple		24 () A	MIN	NV				7. (010	0			0/11	()		
To the Hospital of within 24 hours a To the Funeral D completely filled?		30. Name end eddress of person	who complete	od cause	of death (Ite	m 23a) (Type	Print)	11 5	200	0			0111	150		
To the To the comple		30. Name end eddress of person	who complete	ed cause	of death (Iter		Print)	D 5	re C	ر ا	her M	0	21	615		T



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Month 02 Elsie Conner Johnson 1998 2:50 P.M. 4b. City, Town, or Location of Deeth 4e. Fecility Nama (If not institution, giva street end number) 4c. County of Deeth CAROLINE NURSING HOME, INC. DENTON CAROLINE If Under 1 Year if Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Aga (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Days 1□M 21 F 216-07-4540 Yrs. Jan 15 1904 Maryland Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Caroline Greensboro 1 Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 13230 Greensboro Road 21639 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yas, Giva Yaar or Dates: Wes Decedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2€XNo Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondery (0-12) Collega (1-4or 5+) homemaker own home 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Calvin Edwards Ella Tribbit Edwards 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) James A. Conner 219 S.3rd Street Denton, Maryland 21629 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, Stata Data 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from Stata 2/16 Greensboro Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Greensboro, Maryland 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Fecility Fleegle & Helfenbein Funeral Home P.A. P.O. Box 160 Greensboro, MD 21639 Eleyl 23a. Part1. Enter the disaesa, or complications that caused the death. Do not anter the mode of dylng, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Opent and Death immediete Ceusa (Final disaasa or condition resulting in daath) Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying ceusa given in Part I. 23b. Did tobacco use contribute to the causs of death? 3 Probably 4 Unknown 1 Yes 24b. Wera autopsy findings available prior to complation of cause of death? 24e. Was an autopsy performed?

Physician /Medical Examiner

attending physician and for use as the burial-transit

n signed by the a lid be detached f

cata has been sig.

After this cartificate

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun.

funaral

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Certification:

Medical

27.

31. Data filed (Month, Day,

The law requires that the death certificate be asscuted

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10e. Stata

7th

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Director

x 28a-f show

7 is marked other than "natural", or itema 23a or traumatic event, the Medical Examiner must be

al Hygiena.

permit. Pagas 1 and 2 should be f Department of Health and Mantal I Important: If Item 27 is marked or

other

injury or

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Completed

filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0020

Examiner Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or Injury that initiated events rasulting in deeth) Lest Physician/Medical þ Completed

25. Wes casa rafarrad to medicei

2 No

1 ☐ Yes 2 ☐ No

28. Plaça of Death (Check only one) city)

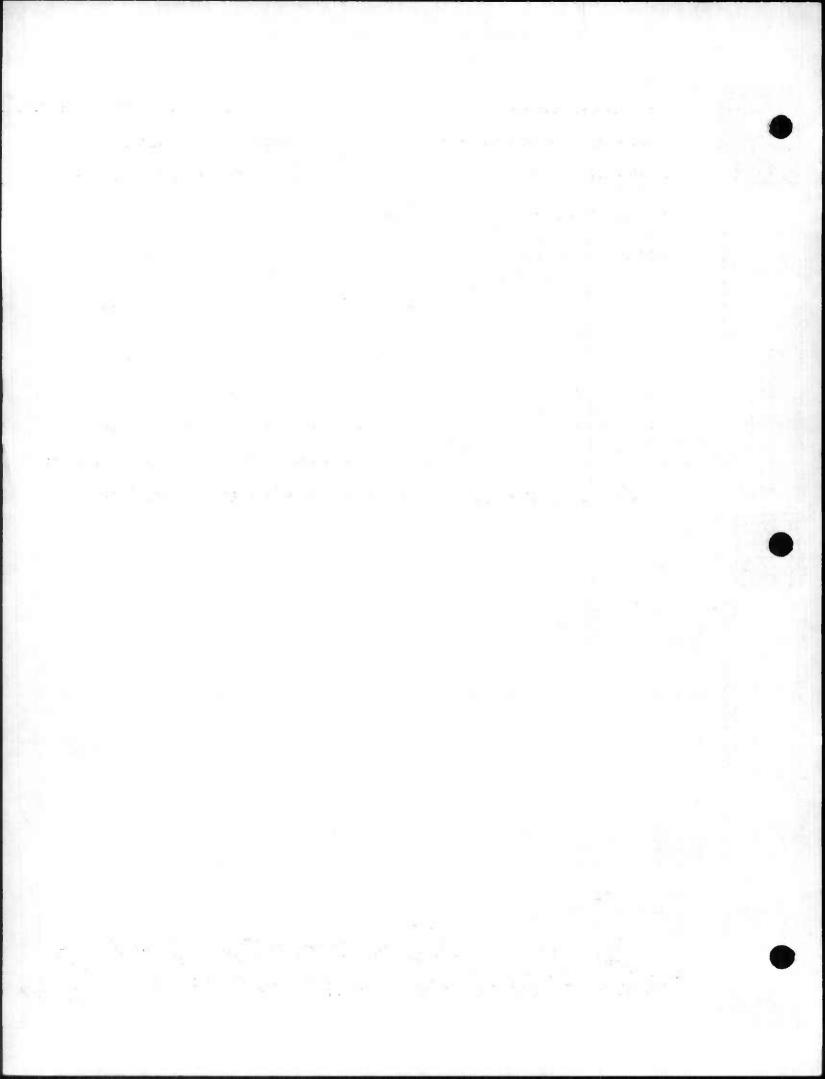
1 Yas 2	4o	1 inpatiant 2	ER/Outpatient	3□ [OOA Otries. 4	Ursing	Homa 5 ☐ Rasidance 6 ☐ Other (Specify)
Mannar of Daath		28a. Date of injury (Month, Day Year)	28b. Time of		28c. Injury et Work?	1	28d. Dascribe how injury occurred
1 Netural 2 Accident	5 Panding investigation		injury	М	1 ☐ Yas		
3 ☐ Sulcida 4 ☐ Homicida	6 Could not be datamined	28e. Place of injury - At h	noma, ferm, straa	t, facto	ory, office		28f. Location (Street end Number or Rural Routa Number, City or Town, State)

4 🔲 Homicida building, atc. (Specify)

(Check only 2 M	edical Examiner: On the	ne basis of exam mennar stated.	inetion end/or invast	gation, in my opinion, death occ	curred at tha time	e ceusa(s) and member es stateo. e, date end place, and dua to tha ceusa(s)
29b. Signetura and titla of	certifiar	0		29c. Licensa number	,	29d. Data signed (Month, Day, Year)

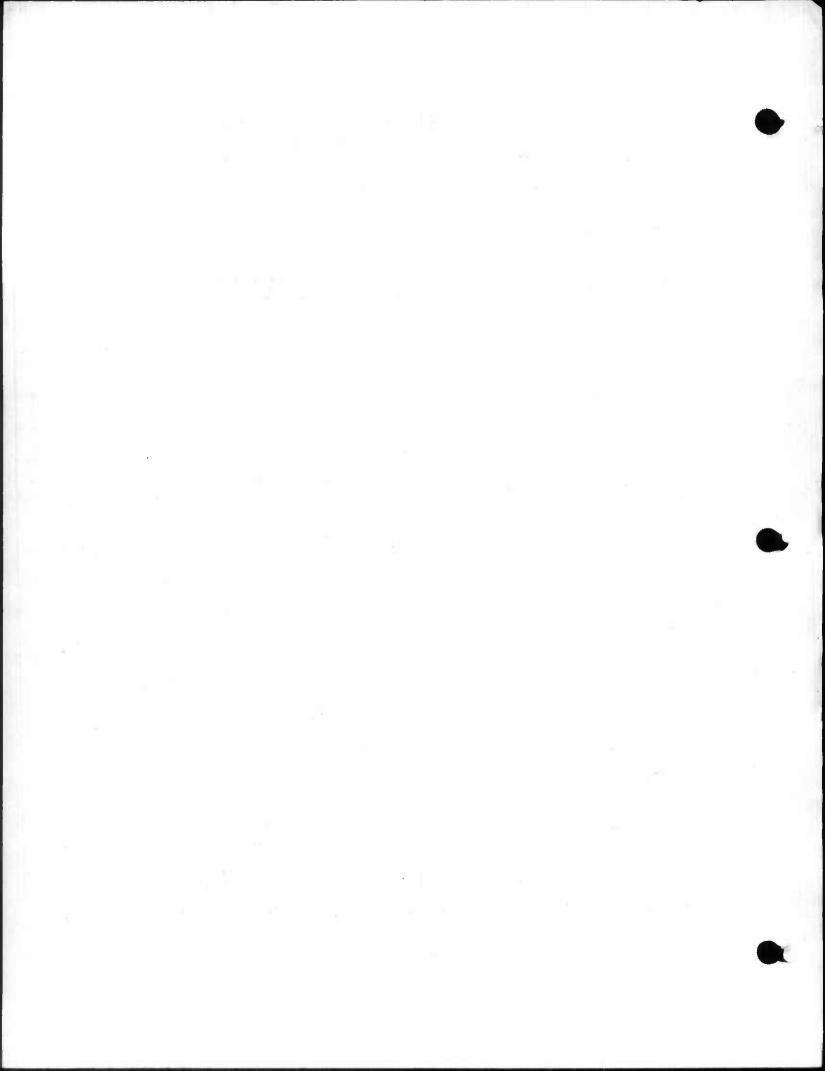
30. Name end

State Registrar



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	1 - STATE REGISTRAR	STATE OF MARYLAN		TMENT OF H		MENTAL HYGIEN		00000
2000	1. DECEDENT'S NAME (First, Middle, Last)	KASOIRVING				2. DATE OF DEATH	1998	
	4. SOCIAL SECURITY NUMBER 2 18 - 07 - 0465	5. SEX 6. AGE (In)	rs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 11/14/	0. B	HRTHPLACE (State or Foreign aryland
TOR	98. FACILITY NAME (II not Institution, give street Spa Genesis El RESIDENCE OF DECEDENT			Annap	olis	EATN	Anne	Arundel
DIRECTOR		Arundel	10c. CITY	, TOWN OR LOCAT		polis	V9	10d. INSIDE CITY LIMITS? 1X YES 2 NO
FUNERAL	113 Domino Road			101	214	01		d States
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. WAS DECEDENT EVER IN U. FORCES? 1 YES	2 NO	If yes, sp	ENDENT OF HISPA Helfy Cuban, Mexico 2 XNO Specific	NIC ORIGIN? (Specify Year, Puerto Rican, etc.) fy:		RACE — American Indian, Block, White, etc. Specify: Black
COMPLETED	15. DECEDENT'S EDUCAL (Specify only highest grade co	FION 16 mpleted) College (1-4 or 5 +)	Give kind of we life. Do NOT use	USUAL OCCUPATION ork done during monor retired.)	en at of working		Marke	
BE COM	17. FATNER'S NAME (First, Middle, Last)	illiam E. J				ME (First, Middle, Meider Ella Al		
TOE	19a. INFORMANT'S NAME (Type/Print) Mary L. Pindell	/Daughter				Route Number, City or Tov nnapolis		
	20a. METNOD OF DISPOSITION 1 (X) Burlal 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	ri from State cometa	ry, cramatory or oth	r place)	ne of netery	1	rlock,	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICEN Milbul 7.			Framp		wkins-Es	kow Fu	neral Home MD 21632
	23. PART I. Enter the diseases, or conshock, or heart failure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	pilestions that caused that only one cause on each	ilne.			h as cardiac or resp	iratory arrest,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF)	k:				,
PHYSICIAN: MEDICAL C	PART II. Other significant conditions of					t TYES	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ICIAN:		26.	PLACE OF DEATH		UNCERTAI	N 🗆		
BY PHYS	1 VES 2 NO 1 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	Inpetient 2 ER/Outpetia 28a. DATE OF INJURY (Month, Dey, Year)	28b. TIME	OF 28c. INJURY	IRY AT	6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCURE	D
- 1	3 Suicide 8 Could not be 4 Homicide dstarmined	28a. PLACE OF INJURY — building, etc. (Specify)	At home, ferm, et	reet, factory, office		26f. LOCATION (Street City or Town, State)		iral Route Number,
COMPLETED		N: To the best of my knowledg						se(a) and menner as stated.
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO CO	At Eden, W	1.0.		29c. LICENSE NUI	70/	29d. DATE SIG	NED (Month, Day, Year)
	ROBERT SCOTT	EDEN, M.	D .) 141	o FOR	est DR	- ANNMO	US MD	21403
	FEB 17 '98	la Dai	Hilson-Par	plan				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 4b Gity, Town, or Location of Deeth Month Voor (nmn) 18 1998 4c. County of Death 4 KehAb Jolumbia UKSIX9 HOWAR D If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) if Under 1 Year 6. Say 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Deys 11☑ M 2□ F 74 Yrs June 26, 1923 Canada 10b. County 10c. City, Town or Location 10d. fnside City Llmits 1 ☐ Yes 2 No

Parkung

Eduction, MO

Pakunt

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White

Approximeta Intervel Between Onset end Death

24b. Were autopsy findings evelleble prior to completion of causa of deeth?

1 ☐ Yes 2 ☐ No

/Medical 4e. Feclity Neme (If not Institution, give street end number) Examiner ORIEN 5. Social Security Number **Funeral** 212-32-2621 Director Usual Residence of Decedent 10e Stete 28a-f show the Medical Examiner must be notified at Director Maryland Anne Arundel Severna Park 10e. Straet and Number 10f. Zip Code 10g. Citizen of What Country? 6 931 Kinhart Ct. items 23a 21146 Funeral 12. Was Dacadant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 11 Maritai Status Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) Race - Amarican Indien, Bleck, White, atc. 1 ☐ Never Memied 2 ☐ Married "natural", or 1 ☐ Yes 2X No Specify: þ Specify: 3X Widowed 4 □ Divorcad Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Helicopter nd Mentel Hygiene. marked other than Elementery/Secondary (0-12) College (1-4or 5+) Machinist Manufacturing 7 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be end Mentel Luke (nmn) Jerrett Belinda (nmn) Pottle 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 Is any Injury or other trau Health Martha J. Madary - Daughter 931 Kinhart Ct., Severna Park, MD 21146 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 0 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Memorial Gardens 2-20-98 Bel Air, Maryland 22. Name end Address of Fecility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or haert feiture. List only one cause on buch line. **Physician** /Medical Immediate Cause (Finel Due to (or s a consequence of): diseese or condition resulting in death) **Examiner** Alydeur's Physician/Medical Examiner Dewestin The law requires that the death certificate be executed for use es the buriel-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760, Due to (or es e consequence of): signed by the el Pert It. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Records, þ director, page 2 should Be Completed 24a. Was an autopsy performed? certificate hes 1 Yes of Vital Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 s after dec. After this 27. Manger of Deeth 1 Deeturel 28a. Dete of injury (Month, Dey Year) Certification: 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? Division or Attending 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 | Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it 1 Certifying Phyeictan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner steted. 29e. Certifier Medical (Check only 29b. Signature end titla of Certifiar 29c. License number 29d. Deta signad (Month, Day, Yeer)

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

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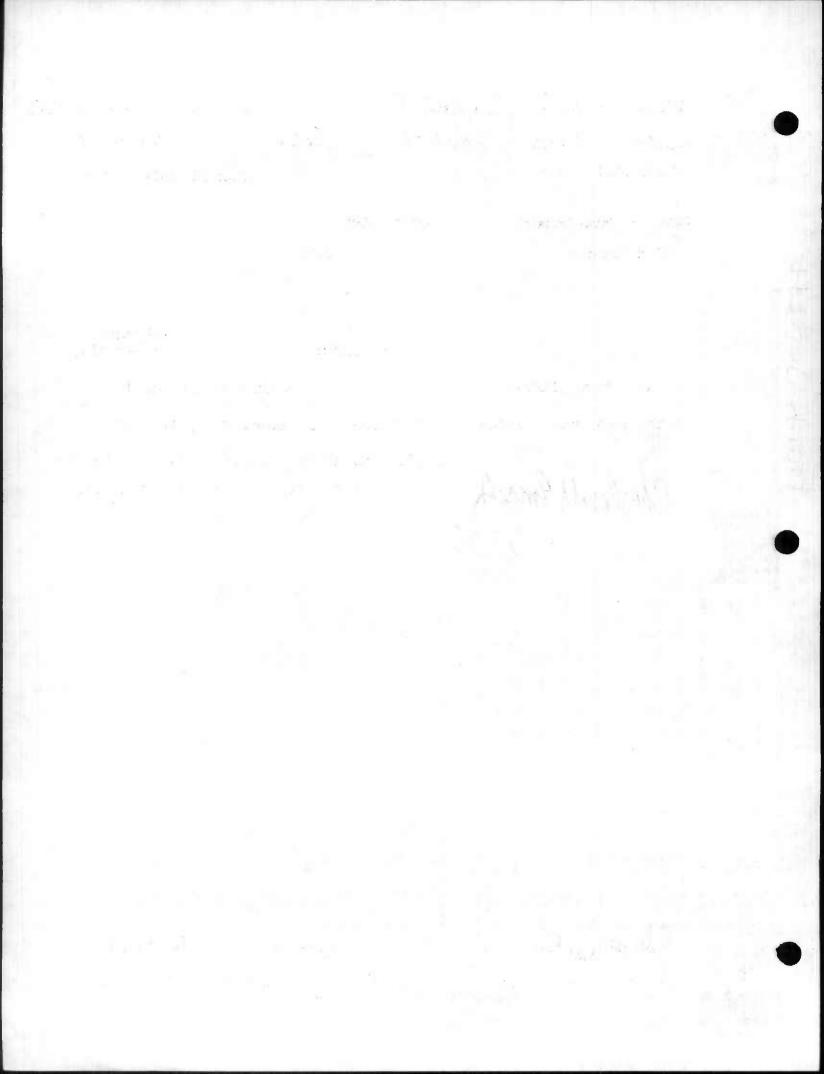
32. Registar's Signeture

State Registrar

DIENCEN

31. Dete filed (Month

Physician



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene J 5 6 0 0 Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1:45 PM rullen February 13 1998 Lynch ledge 111 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Harford | Funder 24 Hrs. | 8. Date of Birth (Month, Day Year Capt. 25, Lorien Nursing & Rehabilitation Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Year) 1⊠M 2□ F Deys Yrs. 1909 Tennessee 88 Director 216-44-3838 Usuel Residence of Deceden the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Abingdon Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21009 USA 200 Olde Woodland Way Funeral death 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 72 hours efter 1 M Yes 2 □ No If Yes, Give Year or Dates: 1941-45 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Aq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 h end Mental Hygiene. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government IRS Agent traumatic event. 18. Mother's Name (First, Middle, Maidan Surname) 17. Father's Name (First, Middle, Last) Be Callie Ann Hebard John Henry Lynch To 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 200 Olde Woodland Way, Abingdon, Maryland 21009 Helen M. Lynch/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 2-17-98 Bel Air, Maryland Bel Air Memorial Gardens 4 Donation 5 Dother (Specify Entombrent 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Part1. Enter the disease, or complications of classed the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause of the death. Approximata Interval Batween Onset and Death **Physician** disease /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner physician end s the buriel-trens Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury Due to (or es e consequenca of): Box 68760 90 Physician/Medicai that initiated events resulting in death) Last Due to (or es e consequence of) 98 esn nse for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Division of Vital Records. P.O. the signed by t 3 Probably 1 ☐ Yes 2 ☐ No by 24b. Ware autopsy findings availabla prior to completion of cause of daath? 24a. Was an autopsy performed? Completed hes pege 2 1 ☐ Yes 1 Yes certificate director 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 0 No To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Natural 2 Accident 5 Pending 1 Yes 2 No death. Investigation ofter death 6 ☐ Could not be datarmined Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide ò Hospital 24 hours Certifying Physician: To the bast of my knowledga, death occurred at tha time, data and place, and due to the causals, and making as states. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. Medical 29a. Cartifiai (Check only one)

108 State Registrar

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30. Name and address of person who cor

29b. Signature and

101 32. Registratis Signature

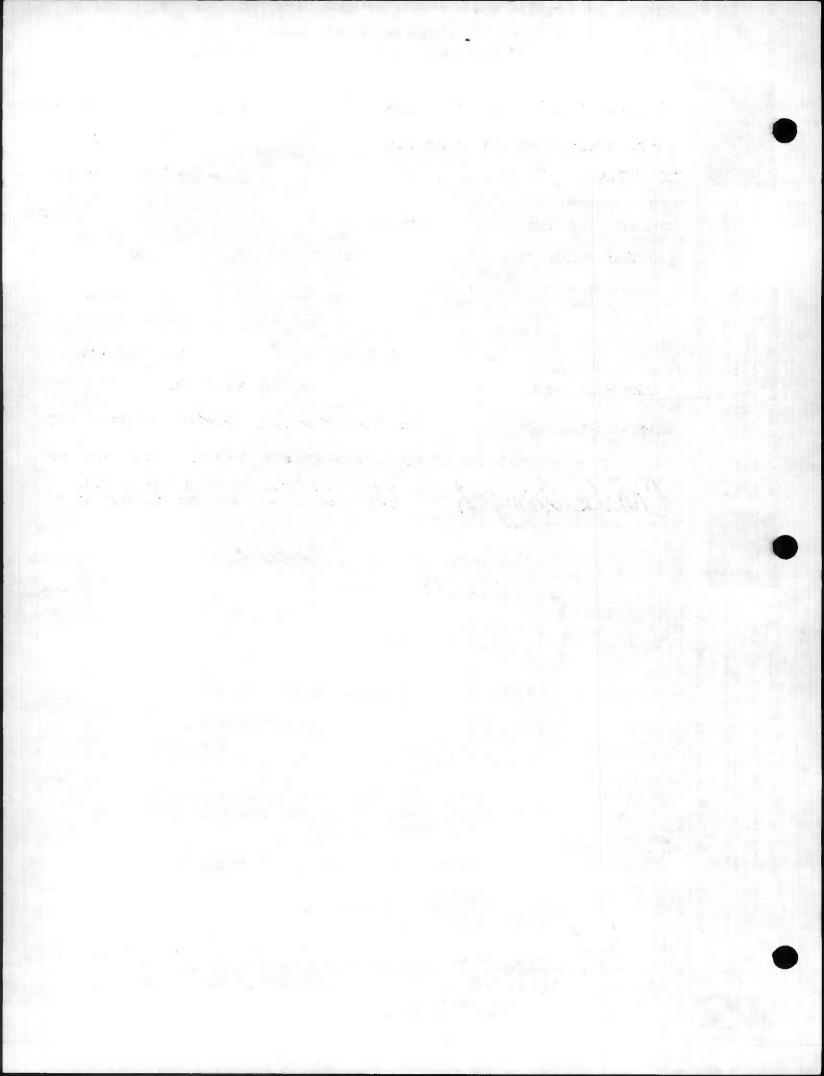
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pleted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

within 2 the th

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle 1 ast) 2. Data of Death Month Hazel Edgar Messick February 17,1998 4:15 AM 4a. Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Daath 4c. County of Death Dorchester General Hospital Dorchester Cambridge 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 1□ M XX F Yrs. 215-01-9150 90 Dec 8, 1907 Maryland Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas XX No Maryland Dorchester Cambridge 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of Whet Country? 10 Shady Drive 21613 U.S.A. 12. Was Dacadant Evar in U,S. Armed Forcas 1 ☐ Yas 22 Ho If Yas, Give Yaar or Datas: Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarlcen Indian, Black, Whita, atc. 1 Nevar Married 2 Marriad 1 Yas ZONo white Widowad 4 □ Divorcad 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) clerk-credit dept. retail 11 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumeme) Grover Tubman Coulbourne Roxie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) Frances Eskridge - daughter 10 Shady Drive, Cambridge MD 21613 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramovai from Stata East New Market Cemetery 2-20-98 East New Market Md. 4 □ Donation 5 □ Other (Spacify) 22. Nama and Addrass of Facility Thomas Funeral Home PA 21. Signature of Funaral Sarvice Licensee 700 Locust St. Cambridge, MD 21613 23a. Parti Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heer failure. List only one cause on each line. Approximata Interval Between Onsat and Daath Immediate Ceusa (Final . Acute suppurative disaase or condition rasulting in daath) ascending cholangitis, probable Dua to (or as a consequance of) Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown dementia

Physician /Medical **Examiner**

the buriel-transit

or Attending Physician: The lew requires that the death certificate be executed

After this certificate

s efter dec.

Hospital within 24 hours e

filled in by

P.O. Box 68760.

Division of Vital Records,

Physician

/Medical

Examiner

10a State

Funeral

Director

ral, or items 23s or 28s-f shore Examiner mant be notified at

7 is marked other traumatic event,

other

= 5

Department of important: If any injury or

. Pages 1 end 2 should be fill iment of Health end Mentei Hillant: If item 27 is marked out

Director

by Funeral

Completed

Be

Physician/Medical Examiner

Be Completed by

Medical Certification: To

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

Sequantially list conditions, if eny, leeding to immadiate ceuse. Enter Underlying Cause (Disease or Injury that Initieted evants rasulting in death) Last

24a. Was an autopsy performad? 24b. Wera autopsy findings available prior to completion of ceuse of death?

25. Was cesa raferred to medicel axaminer? 1 Yas 2 No 27. Manner of Death

Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA

28b. Tima of A

Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier

Natural

2 Accidant

3 Suicida

4 ☐ Homicida

Tertifying Physician: To the best of my knowledge, death occurred at the time, dale end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

26. Placa of Deeth (Check only ona)

5 Panding invastigation

6 Could not be datermined

2.18.98

30. Name end address of person who complated ceusa of death (Item 23a) (Type, Print)

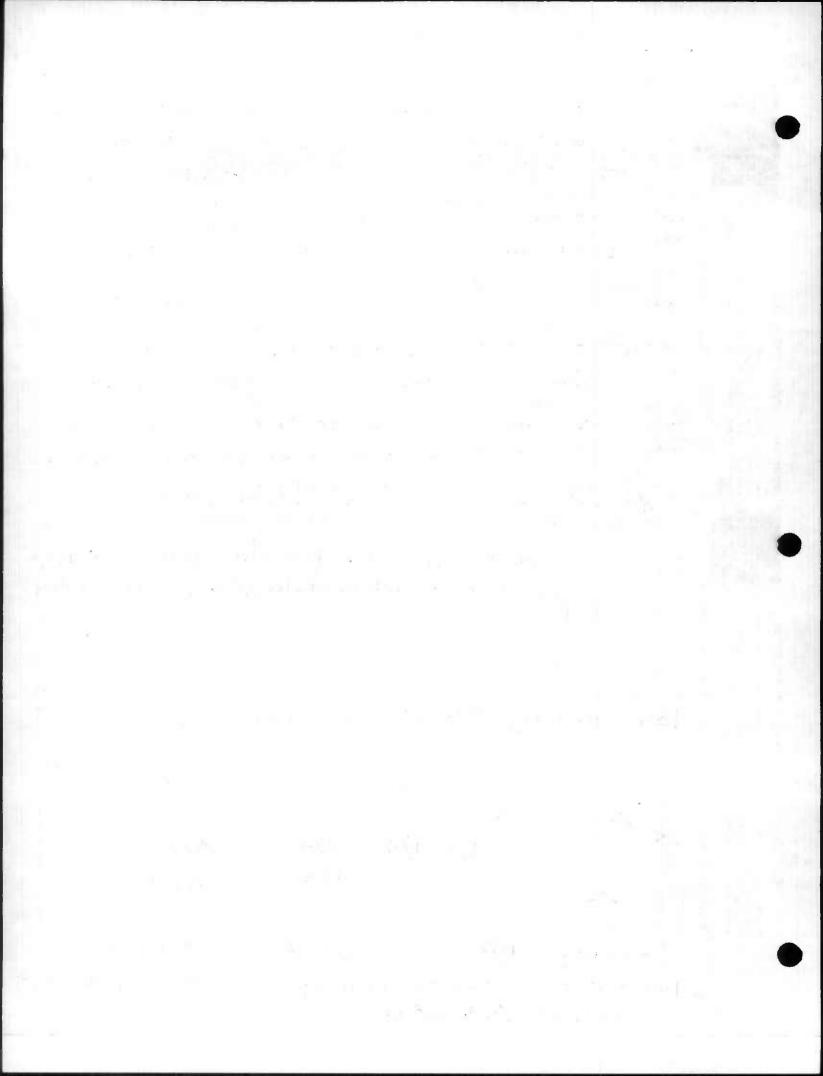
400 maryland Ave. Cambridge ND 21613 WILKE MD

31. Data filed (Month, Day, Year)

29b. Signatura and titla of certifiar

32. Ragistrar's Signatura Jethi Newborkardall

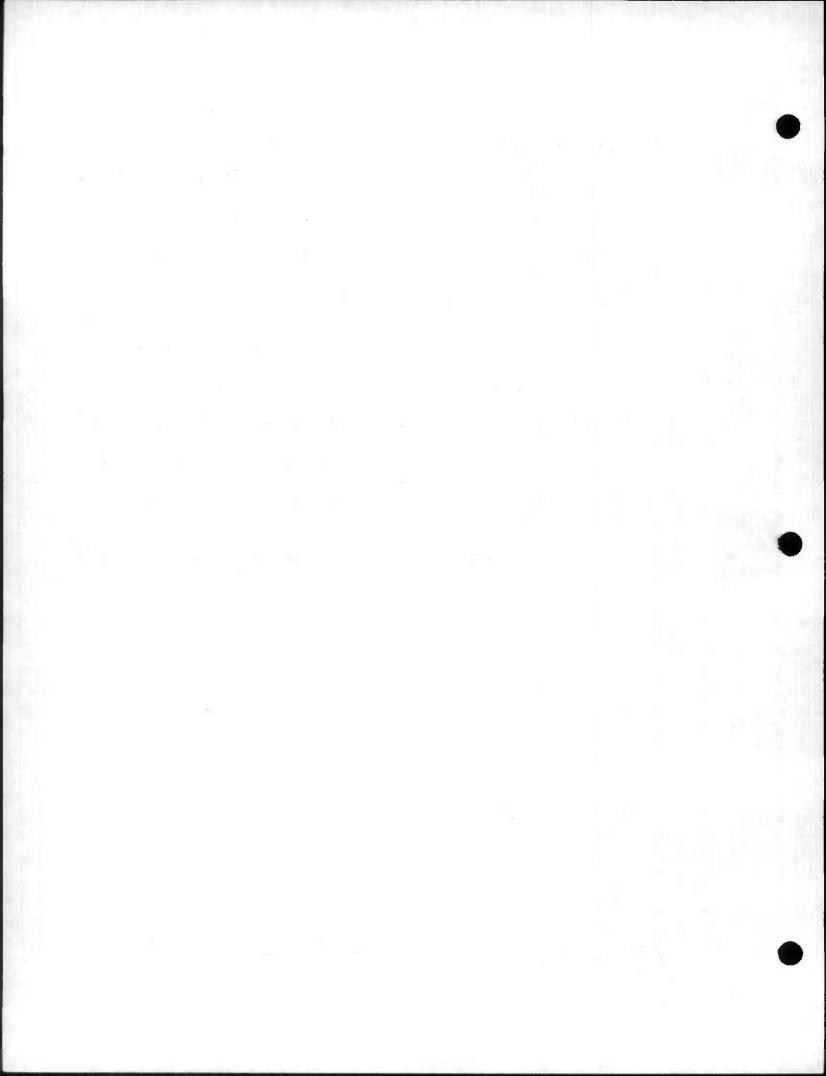
State Registrar



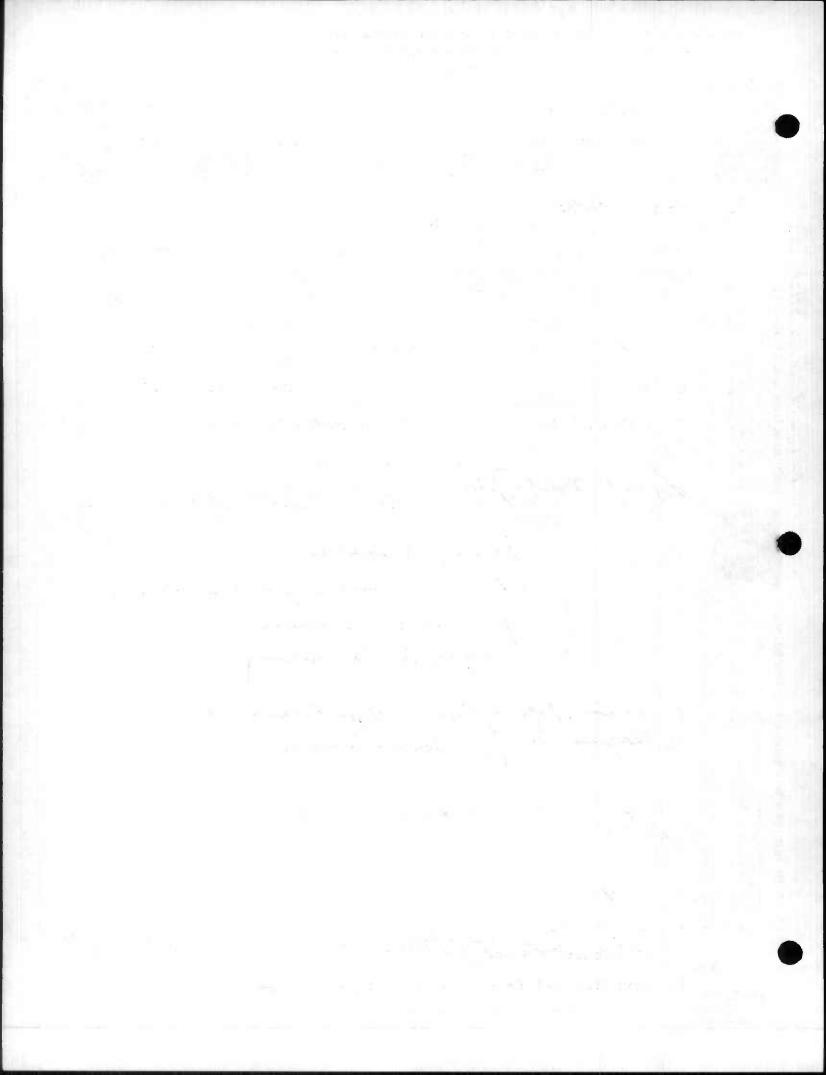
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 25s-f show any Injury or other traumatic event, the Medical Examinet ment be not liked and proper process. To Be Completed by Funeral Director	Memore Security Nemeror Memore Security 2 1 3 - 1 0 Usuel Residence 10a. State MD 10e. Street and N 3 1 1 11. Maritel Status 1 Never Ma 3 Widowed (Sp Eiementery/Se 17. Father's Nam	Number 6. Se - 7555 of Decedent 10b. County Caroli umber Reliance rried 2 Married 4 CDivorced 15. Decadent's Edecity only highest greece	Roy Own street end number) pital @ If ix	7 8	St birthday) Yrs. If Ur Mont Town or Location 10f. 13. Was De If Yes, s	F e Zip Code	4b. City, Town, or East If Under 24 Hrs Hours Min. deralsb 21632 dispanic Origin? (S	00n 8. Dete of Bi (Month, D 05/20 urg	Dey 21, th 4c. County T	Year 1998 of Death albot 9. Birthplece Country) Mary 1 10d. Whet Country?	Inside City Limits 1 ☑ Yes 2 ☐ No
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Attending Physician: or death. ector: After this certific by the funeral director, filcation: To Be (27. Menner of De 1 ⊠Natural 2 ☐ Accident	ath 5 ☐ Pending investigetion	28e. Dete of Injury (Month, Dey Y	'ear) 2	8b. Time of Injury M	28c. Injur Wor 1 🗆	ryet rk? ∣Yes 2 □ No	28d. Describe	how Injury occur	red	
한 분들은 분	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Plece of Injury building, etc. (- At hom (Specify)	ne, farm, street, fac	ctory, office			(Street end Numb wn, Stete)	per or Rurel Ro	ute Number,
he Hospi in 24 hou he Funer pletely fill edical	29a. Certifier (Check only	Certifying Phy Medical Exami	sician: To the best of niner: On the besis of ex	ceminetic	edge, deeth occurr on end/or Investiget	red et the tir tion, in my o	me, dete end piece ppinion, deeth occu	, end due to the rred et the time,	ceuse(s) end me dete end place,	enner es steted end due to the	t. ceuse(s)
To the Hospital within 24 hours or To the Funeral completely filled	290 Eignature er)	end menner state	d.							
5 3 5 0		d title of certifier	08/10	11	MA	29c. Licens	27409		Z · Z	00)
	30. Name and ad	dress of person who d	ompieted cause of deep	th (Item 2	23a) (Type, Print) 606 Du	telimo	n's Lant	Eas	ton, M	0 2160	/
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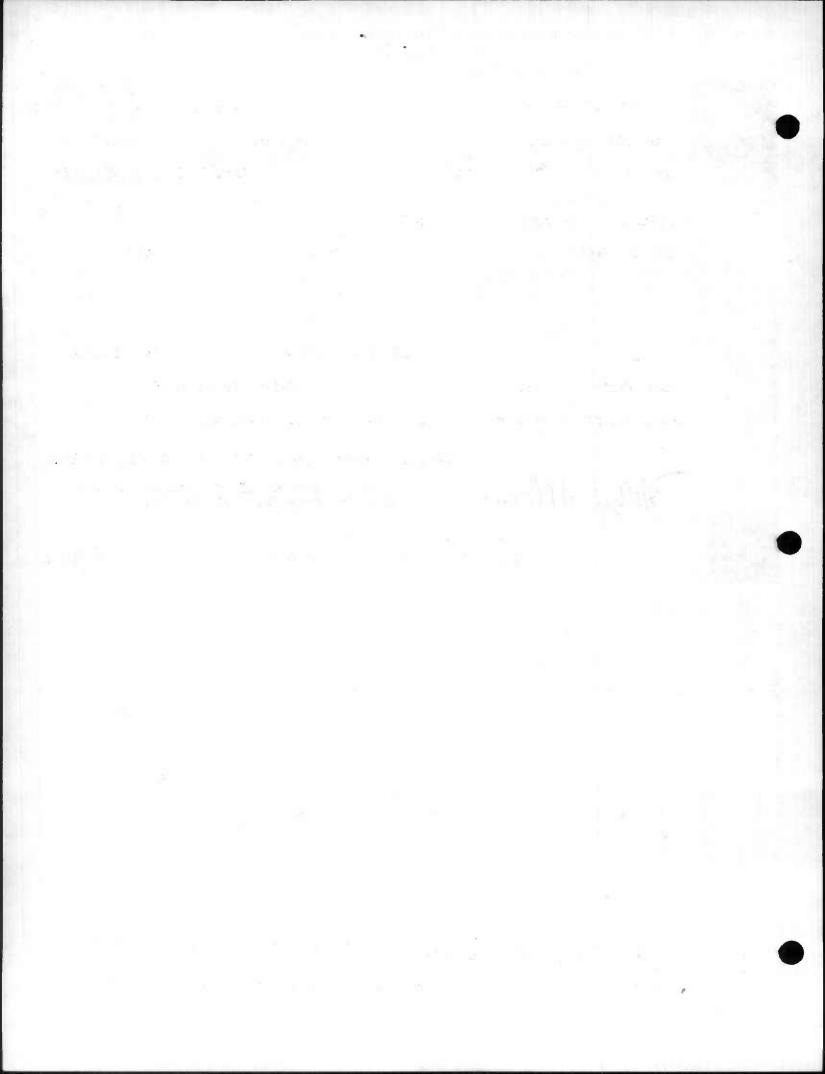
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27 is r fras		DORIS HOLTON /	SISTER			2 KING				NEWBURG		20664		
2 5 5	Ì	20e. Method of Disposition	DIDILIK	20b. PI	ece of Dispo	sition (Nem	e of		עא	Dete	20c. Location			
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Dep III Dep		4 Donetion 5 Other (Specify) HOLLY GHOST CHURCH CEM. 2/24/98 ISSUE, MARYLAND 21. Sentura of Funeral Service Vicensee 22. Nama and Address of Fecility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiretory arrast, intervel Between the control of												
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		30. Neme end eddress of person v	ALIO COMPIGIOG CORSE	OI GOOTH HIGH										



State of Maryland / Department of Health and Mental Hygiene

06604 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Otto Barton McLean February 12, 1998 4:00 AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b, City, Town, or Location of Deeth 4c. County of Death Examiner 312 Old Joppa Rd. Fallston Harford If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number If Under 1 Year 9. Birthplece (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F Deys Yrs. Director 84 Aug. 9, 1913 113-01-6658 Usuel Residence of Deceden the Marylend 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Meulical Examiner must be notified all 1 Yes 2 No Directo Maryland Harford Fallston 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 312 Old Joppa Rd. 21047 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer c Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or itemany injury or other traument. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Broker Real Estate 12 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Otto Barton McLean Emily Susan Ward 19e. tnforment's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jeanne T. McLean - wife 312 Old Joppa Rd., Fallston, MD 21047 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremation 3 ☐ Removel from Stete Bel Air Memorial Gardens 2-16-98 Bel Air, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, Md. 23a. Part1. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or he in future. List only one cause on each line. **Physiclan** /Medical tmmediete Ceuse (Fine) Bronch ogenic diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): the burial-trensit and Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence ot): Box 68760. physician 8 Physiclan/Medical Due to (or es e consequence of): ettending Pert it. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Dtd tobecco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy tindings evelleble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Be Completed peen has page 2 certificate 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attanding Physician: 25. Wes case reterred to medical examiner? 26. Piece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury et Work? Division 5 Pending Investigation 1 Natural efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 ☐ Homicide To the Funerel Dir 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner stated. 29e. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) smorich completed cause of deeth (Item 23a) (Type, Print) M.D. 754 Hickory Avenue Bel A: R. Md. 21014 BONOVich State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Day Frances Margaret Mahan 98 9:10 PM 02-12-4e. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth 3635 Aldino Rd. Aberdeen Harford 8. Dete of Birth (Month, Day, Year) Feb. 18, 1916 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Sociel Security Number 7. Aga (in yrs. last birthday) Birthpiece (State or Foreign Country) Days 1□ M 21 F 219-14-0319 81 Yrs Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Harford Maryland Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3635 Aldino Rd. 21001 USA 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Detes: 1 □ Nevar Marriad 2 □ Merried 1 ☐ Yes 2 ☑ No Specify: White Specify 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) Coilega (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Melden Sumema) 17. Father's Neme (First, Middle, Last) William Ward Fearneyhough Mary Malinda Ritchie 19a. informent's Neme/Relationship (Type, Print) 19b. Melling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) Melinda G. Sefton - Daughter 3635 Aldino Rd., Aberdeen, Md. 20b. Plece of Disposition (Neme of cematery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ⊠ Buriei 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 2-16-98 Aldino, Maryland 21. Sign@urerof Funeral Service Line 22. Name end Addrass of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. Part1. Enter the disaase, or complication that hous shock, or heert feilure. List only one count or each d the deeth. Do not enter tha mode of dying, such es cardiec or respiratory arrest, Approximate interval Between Onsat end Death Immediate Cause (Fine) diseesa or condition rasulting in deeth) MELANOMA 6 MONTHS Due to (or as e consequence of): Due to (or es e consequence of): Due to (or as a consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert ii. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 □ Unknown 24b. Were autopsy findings evalleble prior to completion of cause of death? 24e. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

attending physicien and for use as the burial-transit

been signed by the a should be detached if

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certificate

To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completaly filled in by the funeral director,

P.O. Box 68760.

Division of Vital Records,

Examiner

Physician/Medical

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Completed

Certification:

Medical

permit. Pages 1 end 2 should be filed within 72 hours effer death with the Meryland Depertment of Heelth end Mental Hygiene. Important: If Ifem 27 is marked other than "natural" --- any injury or other traumetic executions.

Physician

/Medical

Examiner

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Funeral

Director

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25. Wes case raferred medical

examiner?

28. Piece of Deeth (Check only oper

ZU No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🖒 inpatient 2 ER/Outpatient 3 DOA 27. Meono of Death 1 Death 28e. Dete of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

2 Accidant 3 Suicide 6 Could not be datamined 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 \ Homiclda

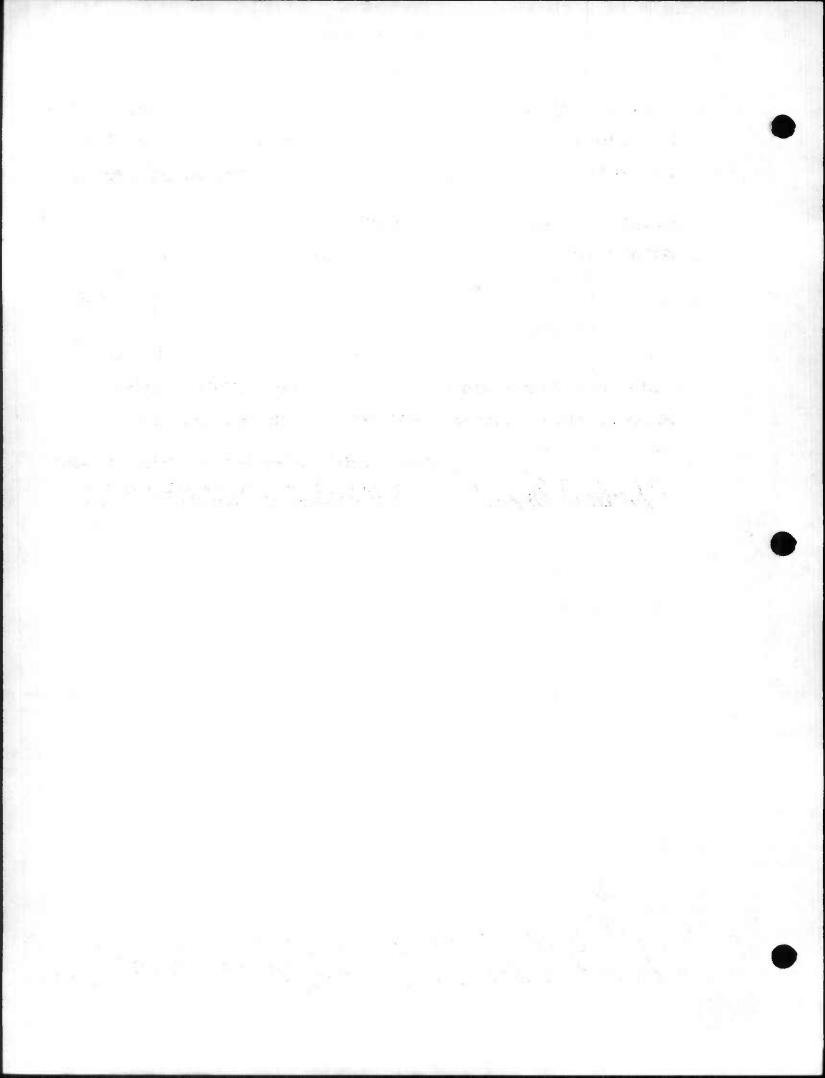
Certifying Physician: To the best of my knowledga, daeth occurred et tha time, dete end piece, end due to tha causa(s) end menner es stated.

Medicat Examiner: On the basis of examinetion end/or invastigetion, in my opinion, daath occurred et the time, dete end piece, and due to tha cause(s) and manner steted.

29a. Certifier

29b. Signatu 29c. Licansa number 29d. Deta signed (Month, Dey, Year)

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month MYERS. MARGARET EL12ABETH FB /Medical 4a. Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH CARE 410 EMCPHAILND HARFOND 3 ELAI2 7. Age (In yrs. lest birthday) | If Undar 1 Yaar | If Undar 24 Hrs. | 8. Dele of Birth (Month, Dey, Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Sax Birthplace (State or Foreign Country) 1□M 2ØF 212-03-6610 Oct. 16, 1916 Maryland Usual Rasidence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Bel Air Direct 10e. Street end Number 10f. Zip Code 10g. Citizen of Whai Counity? 7 Trenton Lane 21014 USA Funeral 12. Wes Decedani Evar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Yas 2 ☒ No If Yes, Giva Yaar or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3⊠ Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service Representative Telephone Company 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middla, Melden Sumeme) Be George Edwin Yeagle Mary Madeline Spath 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ruth A. Howard/Daughter 7 Trenton Lane, Bel Air, Maryland 21014 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stele 1 Suriei 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 2-23-98 Baltimore, Maryland 21. Signature Funeral Service Licensee 22. Neme and Addrass of Facility Howard K. McComas III Funeral Home, P.A. 23a. Part1. Enfort the diffeese, or complications their caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onset and Deeth Immedieta Causa (Final ADWD diseese or condition resulting in death) Due to (or es a consequence of) Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Pert I. 23b. Did tobacco use contribute to the cause of death? DEMENTIA - PROGULLIVE 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? PREJSUNE HYDROCEPHALUS completion of causa of death? 1 Yes 2 No 1 Yes 2 No Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Nas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Neturei 2 Accidani 5 Pending investigation NA 1 ☐ Yes 2 ☐ No ~ A M 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide

or Attending Physician: To the Hospital within 24 hours a To the Funeral Completely filled

POPLET LIZABETH MYERS

Funeral

Director

Peges 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mentel Hygiene.
Int: If fem 27 is marked other than "natural; or fems 23s or 28s-f show iry or other traumatic event, the Macinel Examinal must be notified at

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Physiclan /Medical

Examiner

physician and the burial-transit

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After this certificate has been significated has been significated and formers of the section of

efter death. Director: Aft

State Registrar

Medical

29a. Certifier

29b. Signeture end title of certifiar

G.PRABITU

31. Dete filed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

218 FULFORD AVE BELAR MOZIO14 M. D 32 Registrar's Signeture

DME

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner es stated.

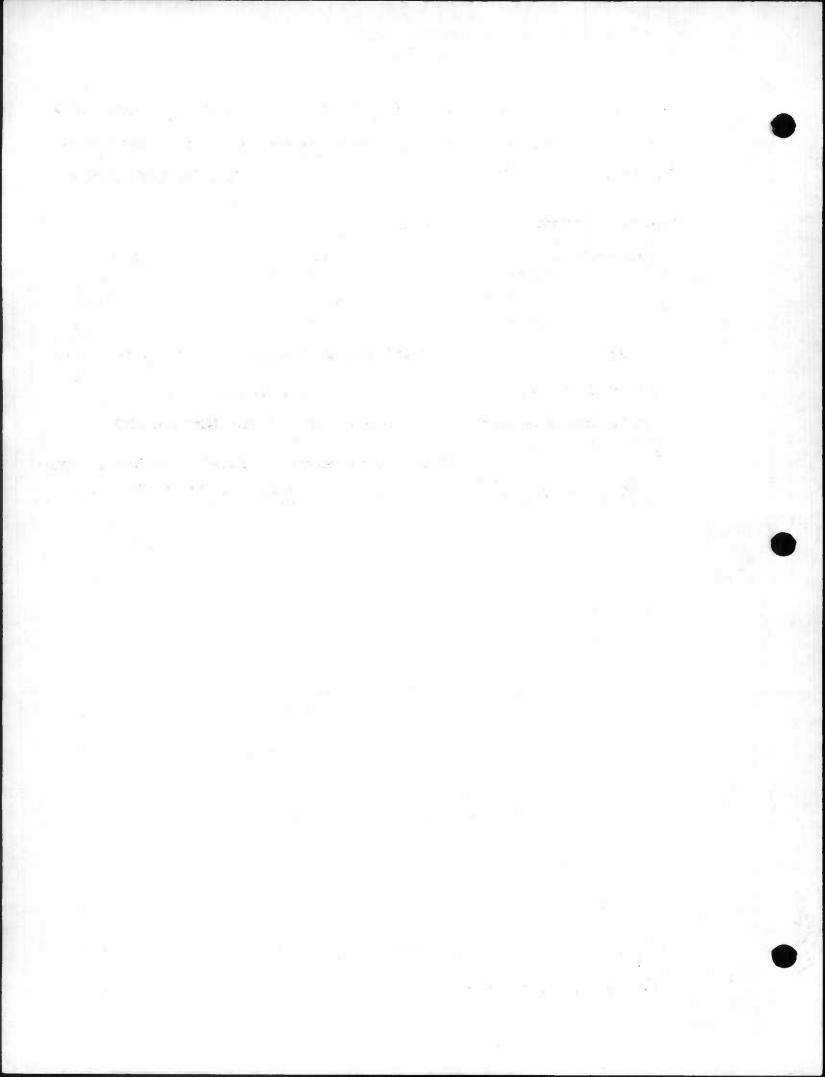
Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. Licensa number

OCME

29d. Daie signed (Month, Day, Year)

19 1998



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Fe bruary 2:13pm **Physician** MALE IRENE MAVIS /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner FallsTON 6 ENERAL | Months | Deys | Hours | Min. | May 11, 1 F-al/570 N HARRONO 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 1□ M 2₽ F 232-36-5048 68 Vrs Director 1929West Virginia Usuel Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryler Department of Health end Mental Hygiena. Important: If item 27 is marked other than "netural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinator must be neutred as 1 ☐ Yes 2 No Directo Maryland Harford Bel Air 10e. Street end Number 10f, Zip Code 10g. Citizen of What Country? 1327 North Fountain Green Road 21015 USA Funeral 12. Wes Decedent Ever in U,S. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Status Armed Forces 1 Never Merried 2 Merried 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ 3 XWidowed 4 ☐ Divorcad Yeer or Dates White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementery/Secondery (0-12) Teacher Public Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Henry Lewis Wildman Belle (u/k)Snodgrass 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) John Male, son RR3, Box 5345, Oakland, Maine 04963 altimore, 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Ignatius Catholic Cem. 2/19/98 Hickory, Maryland 22. Neme end Address of Fecility Howard K. McComas III Funeral Home, P.A. 50 West Broadway Street, Bel Air, Maryland ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, re. List only one cause on each line. Approximete Intervei Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical 11545TOLE Examiner Due to (or es e consequence of): 12hs MOBSAIN COMPLESSION Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest physician and the burial-tran Due to (or es e consequença of) MASSING Physician/Medical 88 esn for Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. ed by the e Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Ves 2 No 3 Probably 4 Unknown (chronic renal failure) Aq 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed COPO (chowic obstaxtive gulmonary disease) hes page 2 CAD (colonary ACTEY disease) 5/0 mI 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer?

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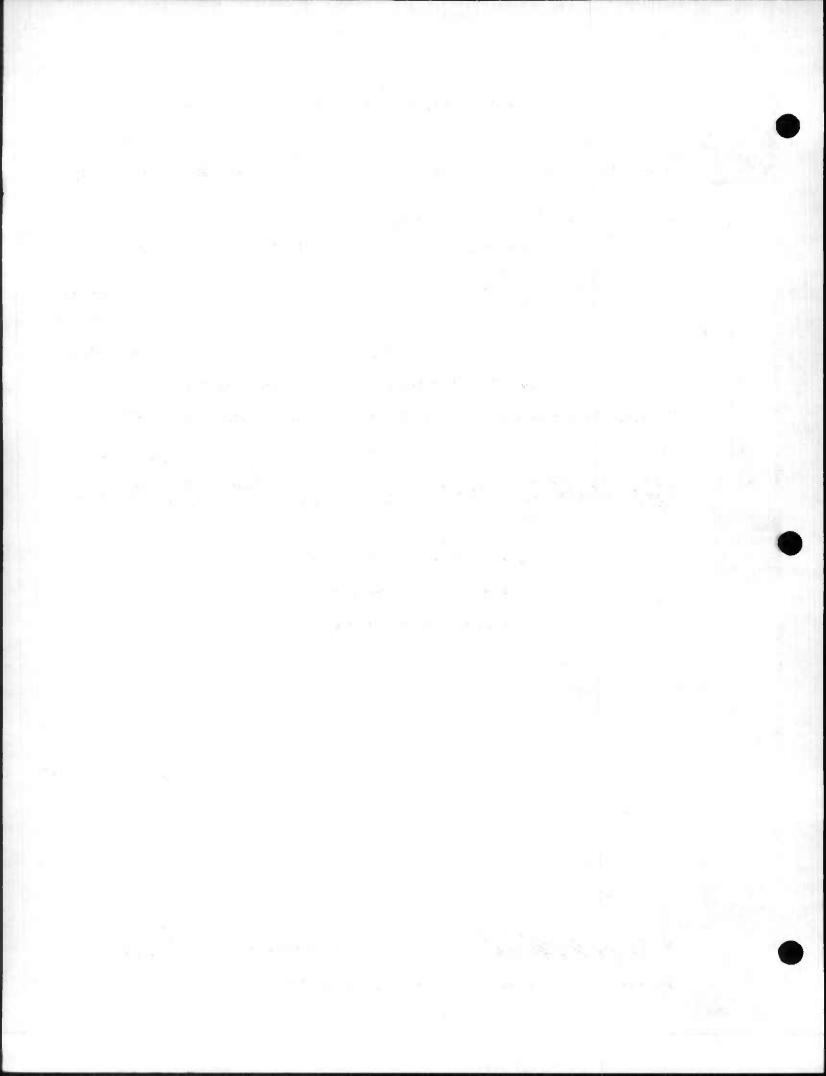
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

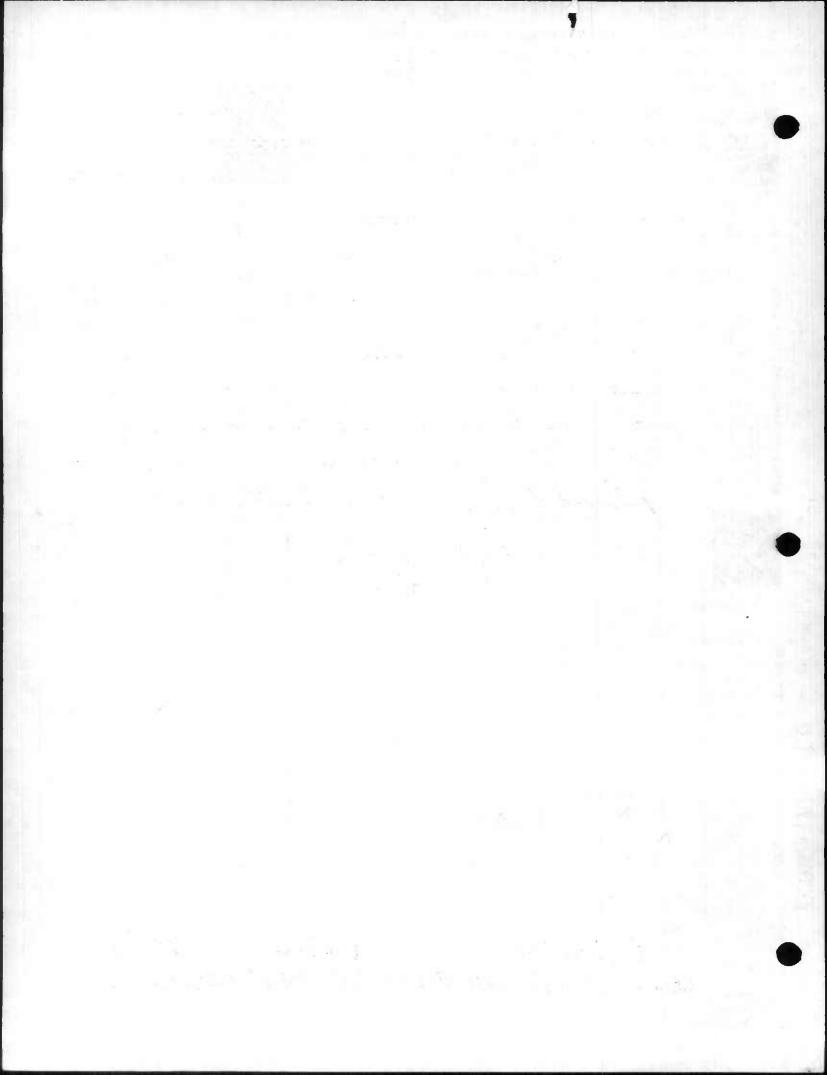
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F F		3 ☐ Suicide 4 ☐ Homicida	6 Could no determin	ned 28a. Plac	ce of Injury ding, etc. (Sp	At homa, farm	n, streat, f	actory, office	3		Location (Si City or Town	treat and Number, Stele)	er or Rural F	Routa Numbar,
within 24 hours efter To the Funeral Dir completely filled in Medical Cert		29a. Cartifier (Check only one)	1 Certifying 2 Medical E	Physician: To the xaminer: On the and ma	na best of my basis of axar annar stated.	knowledge, onination and/	deeth occi or Invastig	urred at the lation, in my	ime, dete end popinion, daath	place, and occurred a	dua to tha ci t tha tima, d	ause(s) and me ata and plece, a	nner as stat and dua to th	ed. na cause(s)
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		Item: 5, per F.H.G-		reb	Ce	ertificate of	Death	2 Data of B	Reg. No.		2 Time - 1
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	dical	Grace Alm 4e. Fecility Neme (If not institution					4b. City, Town, or Lo		17, 1998		5:10 AM
Exar	niner	Harford Memori	_								
- France		5. Sociel Security Number	6. Sex	7. Age (In yrs.	last hirthde	(v) If Under 1 Year	Havre de	_			ana (State or Enraine
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oep	Funerai	11. Maritel Stetus	12. Wes Dec Armed Fo	edent Ever In U	I,S. 13	. Wes Decedent of I	Hispenic Origin? (Spo en, Mexican, Puerto	ecify Yes or No Rican, etc.)		e - America	
Baltimore, Maryland 21215-0020 semit. Peges 1 end 2 should be filed within 72 hours effer deeth with the Maryland Department of Health and Mental Hygiens. Peges and Mental Hygiens. Peges 1 marked other than "natural", or frems 28 or 288-f show my Injury or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Merried 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Yes	20tNo		1 □ Yes ŽIŽNo		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify		
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Mal 12 sh 12 sh 18 m		19a. Informent's Name/Reletions					t end Number or Rure				Code)
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timent:		4 Donetion 5 Other (S		R.		erris & Co		/18	West Ch	ester	, PA
Baltimor permit. Peges Department of Important: If It	2	21. Signeture of Funeral Service	Licensee	1		22. Name end Addre	ess of Facility Cargo Fune	ral Hor	me D A		
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tificate be executed g physicien and es the buriel-transit	edicai	that initiated events resulting in deeth) Lest		Due to (d	or es e conse	equenca of):				1	
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v requires thet the de been signed by the should be detached	by PI							1	Yes 2000	3 L Prob	ebly 4 ☐ Unknown
quire uld b								24a. Wes	en eutopsy	24b. We	re eutopsy findings
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sician: The law scertificate hes birector, page 2 s	Completed							10	Yes 2 DAIL		Yes 2 No
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or Attending F after death. Director: After in by the funer	rtio	1 Netural 5 ☐ Pendir 2 ☐ Accident investi	3	th, Dey Year)	Injury		rk?]Yes 2□No				
or Attending after death. Director: After in by the fune	lfica	3 Suicide 6 Could	not be 28e. Plece	of Injury - At h	ome, farm, s	treet, factory, office			Street end Numb	er or Rurel	Route Number,
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o the of the ompl	Me	29b. Signeture end title of certifie				29c. Licens	se number		29d. Dete signe	d (Month, L	Dey, Year)
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		30. Name end eddress of person	who completed caus	G []	3i- (Type	ALIB	APRELIA) FDF L	, mo	7 100	/
	tota.	31. Dete filed (Month, Dey, Yeer)	30 1	Tegistrar's Sign	ature	inc/ (u)	1 Vieces		1 vod	ice ((
Regi	State strar		7 1998	legistrar's Signi	lear Re	dall					
5.		LEDT	1330								

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Year Wayne Jackson Parks, Sr. 1998 21 Feb 11:25 p 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 25253 Sunset Ave. Greensboro Caroline If Under 1 Year If Under 24 Hrs. | Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Deys 10XM 2□ F Yrs 231-16-1292 76 May 27 1921 Virginia Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 25253 Sunset Ave. 21639 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ⊠Yes 2 No If Yes, Give Year or Detes: 42-43 1 □ Never Married 2 Nerried Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Heavy equipment operator construction 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Lewis M. Parks Vernia Venable Parks 19e. Intorment's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Carol Jean Parks/wife 25253 Sunset Ave. Greensboro, Maryland 21639 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel trom State 4 □ Donetion 5 □ Other (Specify) Concord Cemetery 2/26 Denton, Maryland 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Fleegle & Helfenbein Funeral Home, PA P.O. Box 160 Greensboro, MD 21639 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart tailure. List only one ceuse on each line. Approximete Onset and Death Immediate Cause (Final disease or condition resulting in death) CHBONIC Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of):

Physician /Medical Examiner

physician end the buriel-transit

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by

Completed

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Medical Certification:

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this funeral

Hospital or Attending Ph.
 24 hours effer death.
 Funeral Director: After th.

within 24 hours e To the Funeral D

Box 68760.

Records, P.O.

Division of Vital

Physician

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Director

Funeral

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, in Moorcal Examinar must be notified at

the Meryland

72 hours efter death

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within:
Department of Health and Mantel Hygiene,
Important: if I tem 27 is marked other than "n
any injury or other traumation.

Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Lest Physician/Medical

31. Date tiled (Month, Day, Yeer)

FFB26

Pert II. Other atgnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed?

24b. Were eutopsy tindings eveilable prior to completion of ceuse of deeth?

1 Yes

1 ☐ Yes 2 ☐ No

25. Wes case reterred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 Yes 25 No Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28c. tnjury et Work? Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident

6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 ☐ Homicide

Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

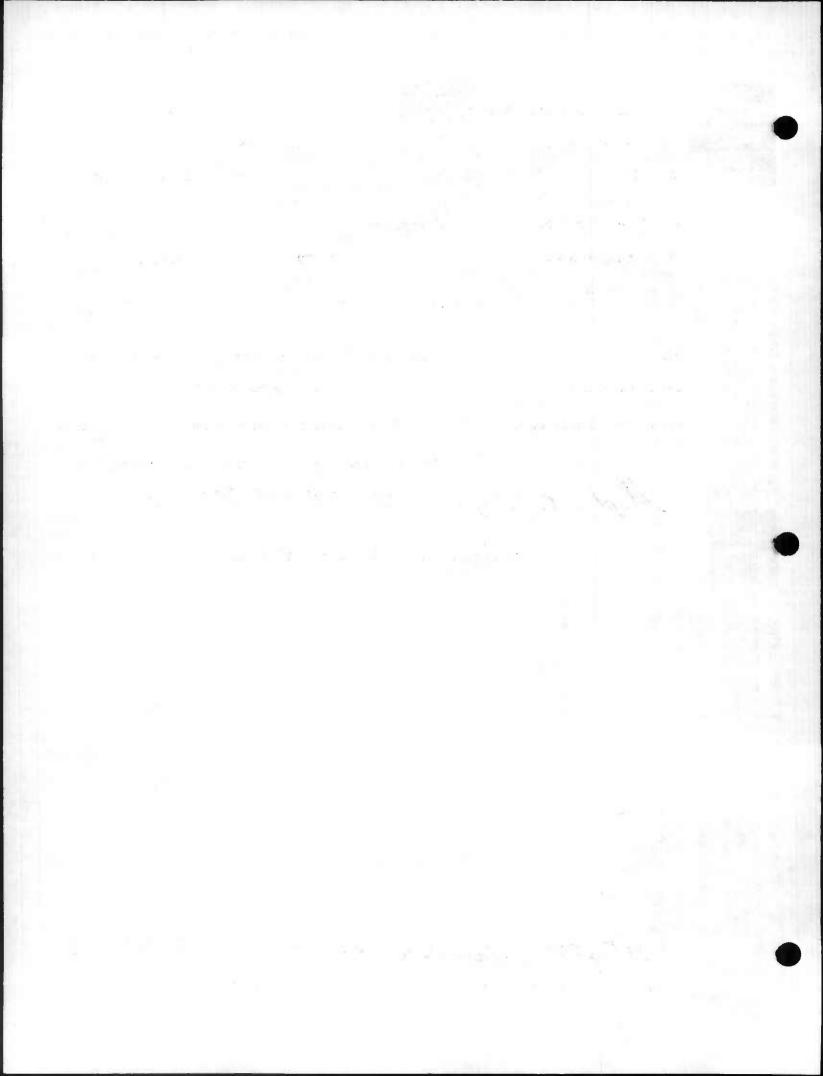
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29a. Certifier

(Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture englittle of certities

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

Stephen P Carney, MD 509 Idlewild Ave. Easton, MD 21602

State Registrar 32. Registrer's Signeture -1- Randell



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Evelyn H. Peterson 02 1998 16 1825 4a. Facility Name (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 02/22/1914 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) N Days Min. Hours 1□ M 20XF Months Yrs 83 216-07-4464 Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Revolution St Apt 206 21078 USA 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowad 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 1 year Clerk Government 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Malden Surname) Austin G. Hanners Abigail G. Whitaker 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 Law St. Austin Harryman- nephew Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Parkwood Cemetery 2/20/98 Baltimore, WD 21. Signature of Funaral Service Licenses 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A 123 S. Washington St. Havre de Grace, MD longe Hampton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Betw Immediata Cause (Final disease or condition rasulting In death) Saquentially list conditions, if any, leading to immediata ceuse. Enter Underlying Causa (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably nknown 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Opatient 2 ER/Outpatient 3 DOA

Examiner physician and the burial-trans Divisioh of Vital Records, P.O. Kelinson been signed by should be detact page 2 : certificate Hospital or Attending Physician: funeral diractor, After s after death.

Physician

/Medical

Examiner

Funeral

Director

28a-1 show

Director

Funeral

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Physician/Medical

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Be Completed

Medical Certification: To

27. Maphar of Death

Natural

2 Accident

3 Suicide

29a. Cartifiar

31. Data filed

5 Panding

invastigation

28a. Data of Injury (Month, Day Year)

28b. Time of

traumatic event, the Medical Examiner must be notified at

the Maryland

with ò items 23a

death

2 should be filed within 72 hours after on and Mental Hygiena.
Is marked other than "natural", or item

Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event,

Physician /Medicai

Pages 1 and

Baltimore, Maryland 21215-0020

within 24 hours a
To the Funeral C 10

To the

filled in by

6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 Homicide Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

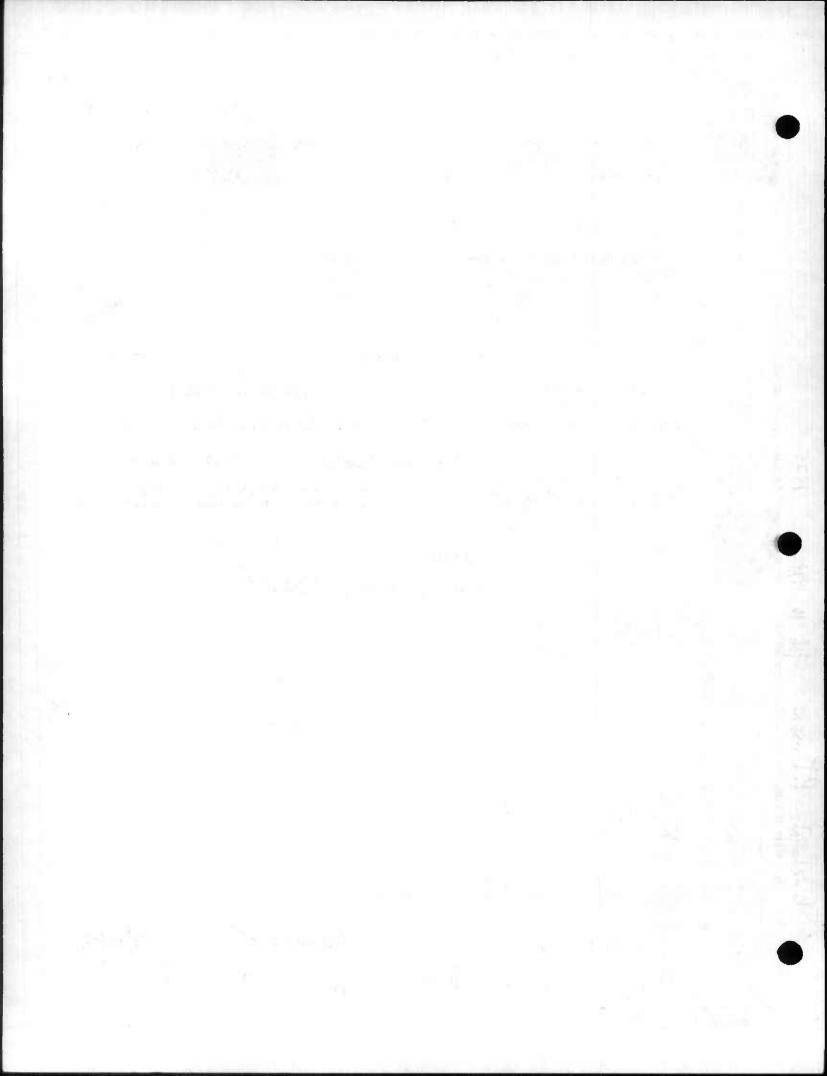
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Nonth, Day, Year) 29b. Signature and title of certifier 29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

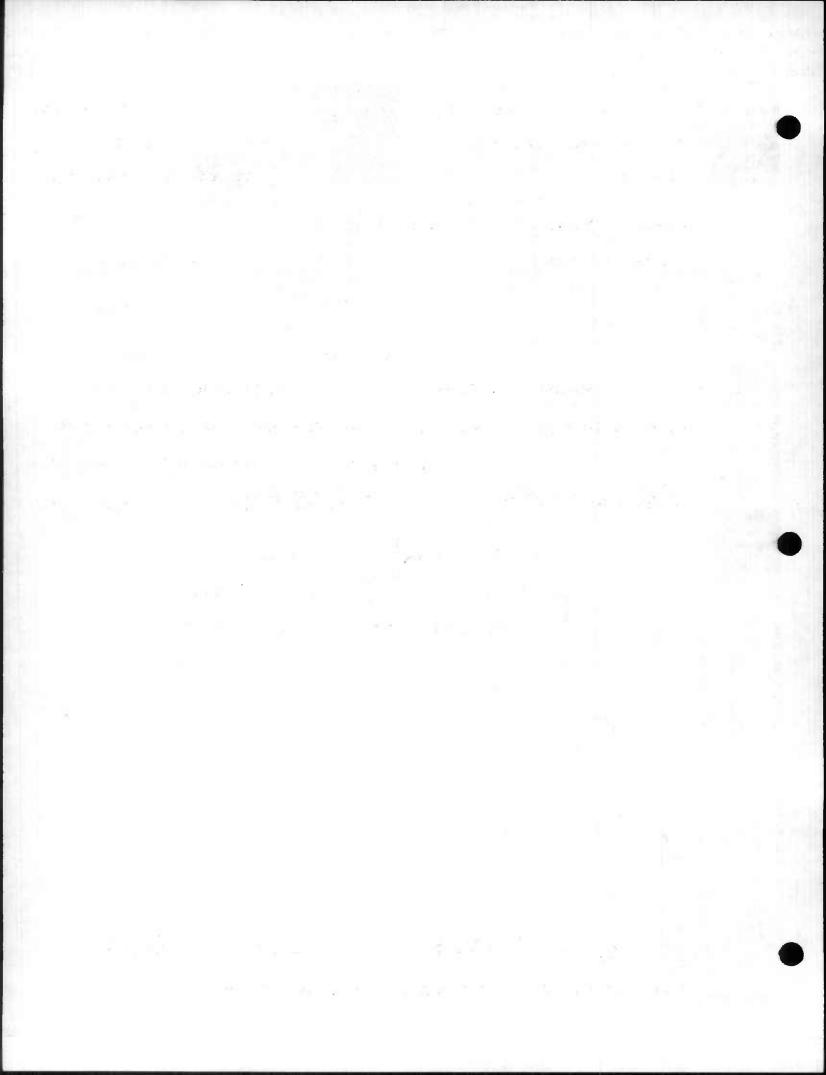
28d. Describe how Injury occurred

State Registrar



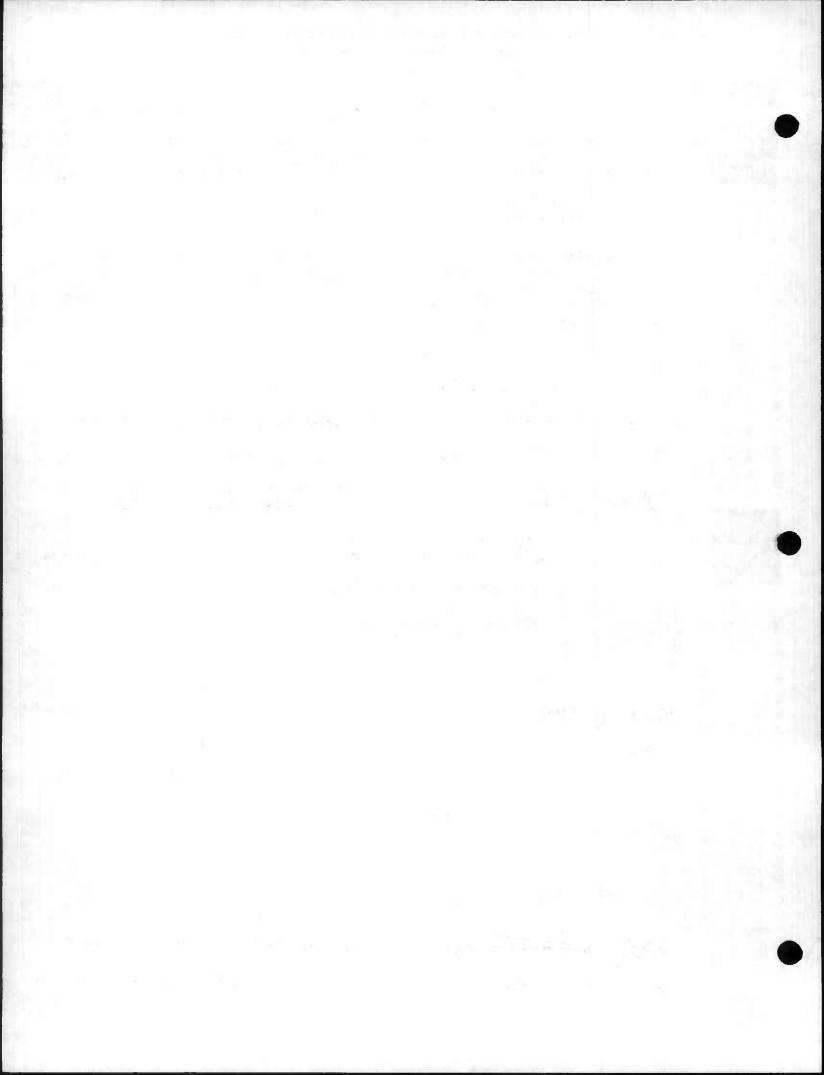
State of Maryland / Department of Health and Mental Hygiene Q

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Н	C			n yrs. lest birthday)	If Under 1 Year	Denton If Under 24 Hrs.			oline	(State or Engine				
X.	Funeral Director		216-18-2308 B 1□ M 2√F Usuel Residence of Decedent	86 Yrs.	Months Deys	Hours Min.	8. Dete of Birth (Month, Dey, October 9,	Year) 1911		(Stete or Foreign Carolina				
	72 hours efter death with the Marylend netural; or items 23a or 28a-f show dical Examiner must be notified at	_		c. City, Town or Lo	cation					nstde Ctty Limits				
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	th th	Olre	10e. Street end Number	(70	10f. Zip Code		10	g. Citizen of W	het Country?					
	th w		401 Maryland Avenue		21660		IIn	ited St	tates					
	dea Lis	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U,S. 13. V		Hispente Orlgin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race	- American Ir	idien,				
0	ofter or the		1 Never Married 2 Married 1 Yes 2 No				nican, etc.)		c, White, etc.					
02	er.	by	3 Widowed 4 □ Divorced If Yes, Give Yeer or Dates:		I□Yes 2□KNo	Specify:		Specify:	casian					
0-10	"neturel",	ted	15. Decedent's Education	16a. Deced	lent's Usuet Occup	petion	. 10	6b. Kind of Bus		у				
21215-0020	within 72 ho jiena. r than "natur	Completed	(Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+)	life. L	kind of work done DO NOT use retire	during most of works d)	ing							
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Baltimore,	or or or		1 Buriat 2 ☐ Cremation 3 ☐ Removel from Stete	20b. Pleca of Dispos cemetery, crem	netory or other ple	ca)	Dete	Oc. Location - C	JRY OF TOWN, 3	51616				
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•	Dep Per Sun Sun Sun Sun Sun Sun Sun Sun Sun Sun		* Kandolph A. Moore	Ņ	loore Fur	neral Home	, P.A.							
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	/Medical		Immediate Ceuse (Final		D. 0	`								
	Examiner		disease or condition resulting In death) e.	ation	1-100	monia								
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Вох	the daath cert y the attendin ached for use	an/	u											
	daa be at	SICI	Part II. Other significant conditions contributing to death but no	ot resulting in the un	derlying cause giv	ven in Pert i.	23b. Did tob	acco use conf	tribute to the	cause of death?				
<u>О</u>	thet the da	Physician/	11 10 0				1 ☐ Yes	2 No	3 Probably	4 Onknown				
	es the igned be da	by F	Hypertension							^				
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of Vital	Physician: this certific ral director,	Be	25. Wes case referred to medical examiner?		100	26. Place of Deetl	(Check only one)						
5	5 00	2	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient	2 ER/Outpetien	3LI DOA		me 5 Residen							
	ng P fter t	:Lo	27. Manner of Deeth 1	28b. Time of Injury	28c. Inju Wo		28d. Describe hov	v Injury occurre	ed					
Division	eth.	at	2 Accident investigation		M 1	Yes 2 □ No								
Š	er der der by t	tiffic	3 ☐ Suicide 6 ☐ Coutd not be determined 28e. Pleca of Injury building, etc. (5	At home, farm, stre	et, fectory, office		28f. Location (Stre City or Town,		er or Rurel Rou	ite Number,				
$\bar{\Box}$	s aft	Certification:	bullarily, etc. (c	peony			ony or rown,	0.0.07						
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner)	minetion end/or inv	occurred et the tie	me, dete end pteca, opinton, deeth occurr	end due to the ceu ed et the time, dat	use(s) end men te and plece, at	nner es steted nd due to the	cause(s)				
	the the	Med	one) end menner steted											
	5 × 5 0	255 555 555 555 555 555 555 555 555 555								rear/				
			1 Janen Visi	reo m	(1)	51637		2 (20)	148					
			30. Name end eddress of person who completed cause of death	(Item 23e) (Type, I	Print)									
			Karen Moffett, M.D., 609 paf	fin Iana	Denton	Maryland	21629							
	Sta	te	31. Dete filed (Month, Dey, Year) 32. Registrer's	Signeture Signeture		Maryland	61069							
	Registr	ar	FFB20 '98	willson-Hand	2020									



State of Maryland / Department of Health and Mental Hygiene 98

						Certificate of	Death		Reg. No.	00013
		J	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
	Physic /Medi			Carlton	N. Ru	ıf, Sr.		Feb.	10. 1998	
	Exami		4a. Facility Neme (If not institution, give	street and number)			4b. City, Town, or Le			
			Dorchester Gen				Cambrid	g e	Dorche	ester
	Funeral Director		5. Social Security Number 6. Security Number 215-26-4513	7. Age (li	7 2	thday) If Under 1 Year Months Days		8. Date of Birt (Month, Da) 06/10	100	Birthplace (State or Foreign Country) Aaryland
	land		10a. State 10b. County	10	c. City, Town	n or Location				10d. Inside City Limits
	he Mary 28a-f sh	Director	MD Dorch	ester			Hurlock			1 ☐ Yes 2√☐ No
	ath with the 23a or 3	rai Dir	5021 Mt. Zion			10f. Zlp Code	21643		10g. Citizen of What United	
21215-0020	within 72 hours efter death with the Maryland iten. iten. Than "natural", or items 23a or 28a-f show the Modical Exercine must be northed at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 4		13. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
5-0	natural",	Completed	15. Decadent's Edu (Specify only highest grad	cation e completed)	16a.	Decedent's Usual Occu	pation	ina	16b. Kind of Busine	ess/Industry
121	within ene.	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	т.	(Give kind of work done life. DO NOT use retire	-		Trucking	7
2			17 Feebada Nama (Fired Middle 1 and)		l r	ruck Drive				
and	S as b	Be	17. Fether's Name (First, Middle, Last)	eorge J.	Duf			Nichol	Maiden Surname)	
Maryland	d 2 should by and Mental hand Mental hand Mental hand Mental hand hand hand hand hand hand hand hand	To	19a. Informant's Name/Retationship (Ty			. Mailing Address (Stree	L			To Oak I
	d2 sthar Tis		Lettie V. Ruf/)21 Mt. Z				
re,	f Health tem 27 other tr		20a. Method of Disposition			Disposition (Neme of y, crematory or other pla		Date	20c. Location - City	
Baltimore,			1)□Burial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)			ern Shore		2/13	Hurlock.	, Maryland
alti	permit. Pege Depertment of Important: If any Injury or once.		21. Signature of Funeral Servica Licanse			22. Nama and Addr	ess of Facility			
0	80 E 8 8		Mulial 7. Gel	Funeral	Home					
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	death. Do r	not enter the mode of dy	ing, such es cardiac	or respiretory ar	rest,	Approximate Interval Between
	Physician					1 1/				Onset end Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Medin	OA	whithen	W1			Home
		-	resulting in death)	Due	to for as a	consequence of)				10
	nsit	min		Genera		11-CVI)			10/5
Š	tificate be executed ig physicien and es the buriel-transit	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury	Ala -	to (or as a c	consequence of):				
68760,	s be	cal	that initiated events	MATOINA	10 (or as a c	onsequenca of):				
	iffical ng ph	Medical	resulting in death) Last	200	10 (01 45 4 0	orrandania orr.				
Box	ettendir for use			l						
	deal he eft ed fo	sici	Pert II. Other significant conditions con	tributing to death but no	ot resulting In	the underlying cause gi	ven in Pert I.	23b. Dld t	obacco use contrib	outs to the cause of death?
0.0	requires thet the death centificate be executed seen signed by the ettending physicien and hould be deteched for use as the buriel-transit	Physician/	History of CUA					101	/es 2□No 3□	Probably Munknown
Vital Records,	uires n sign	d by	, 1,0					24a. Was	an autopsy 24	4b. Were autopsy findings
Ö	- AJ (I)	Completed	GOUT						med?	available prior to completion of cause
Re	The lew ate hes b page 2 s	mc						400	00 6 Tay	of death?
ā	ician: The certificate rector, pag	Be Co	25. Was case referred to medical				OC Diseased Death	1 U Y	65 / 110	1 Yes 2 1
		ToB	eveminer?	lospital:	25 ER/Ou	tpatient 3 DOA Ot	26. Place of Death		ence 6 Other (5	Snacify)
J of	g Physical distribution		27. Manner of Death	28a. Date of Injury (Month, Day Ye		Ime of 28c. Injury			ow Injury occurred	эроснуу
Š	Attending r death. actor: After by the fune	atio	Natural 5 Pending investigation	(Month, Day 10	ar, II		Yes 2□No			
Division	7 2 2 0	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Placa of Injury - building, etc. (S	At home, fai	rm, street, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	urs el urs el urai D									
	To the Hospital of within 24 hours of To the Funeral D completely filled it	edicai	29a. Certifier Check only one) Certifying Physical Examination	Iclan: To the best of my ar: On the basis of exa and manner stated.	y knowledge, minetion end	death occurred et the ti For Investigation, In my	me, date and ptaca, opini <i>on</i> , death occurr	and due to the o ed at the time, o	euse(s) end manne late and placa, end	r as stated. due to the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier	and marmer stated.	-	29c. Licen	se number		29d. Dete signed (M	onth, Day, Year)
	F \$ F ō		mit	The o	1					
			30. Name and eddgess of person who co	moleted cause of death	(Item 23a) (Type Print)	0 - 0		//	1110
			/Michael	Faclden	MES	302 Cd11	ins Ave	Hur	bol me	1998
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature			-101		
	Registr	ar	FP 11 3	98	lia David	Son-Ro				

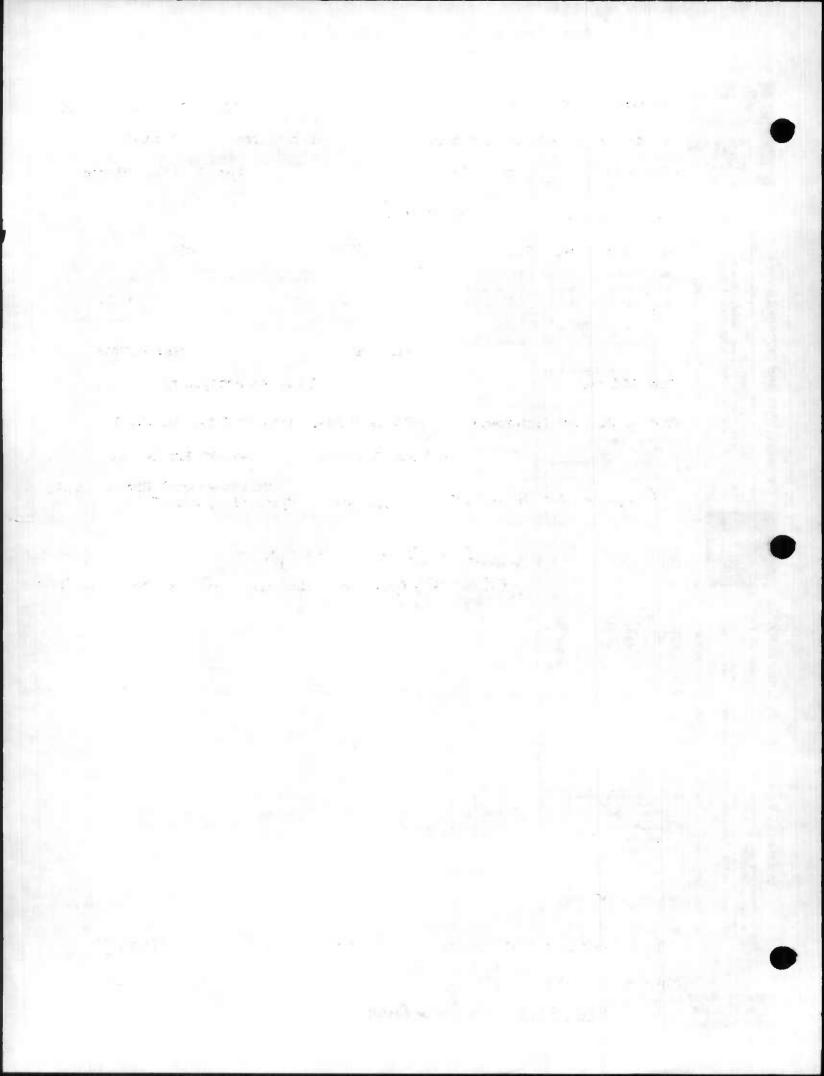


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

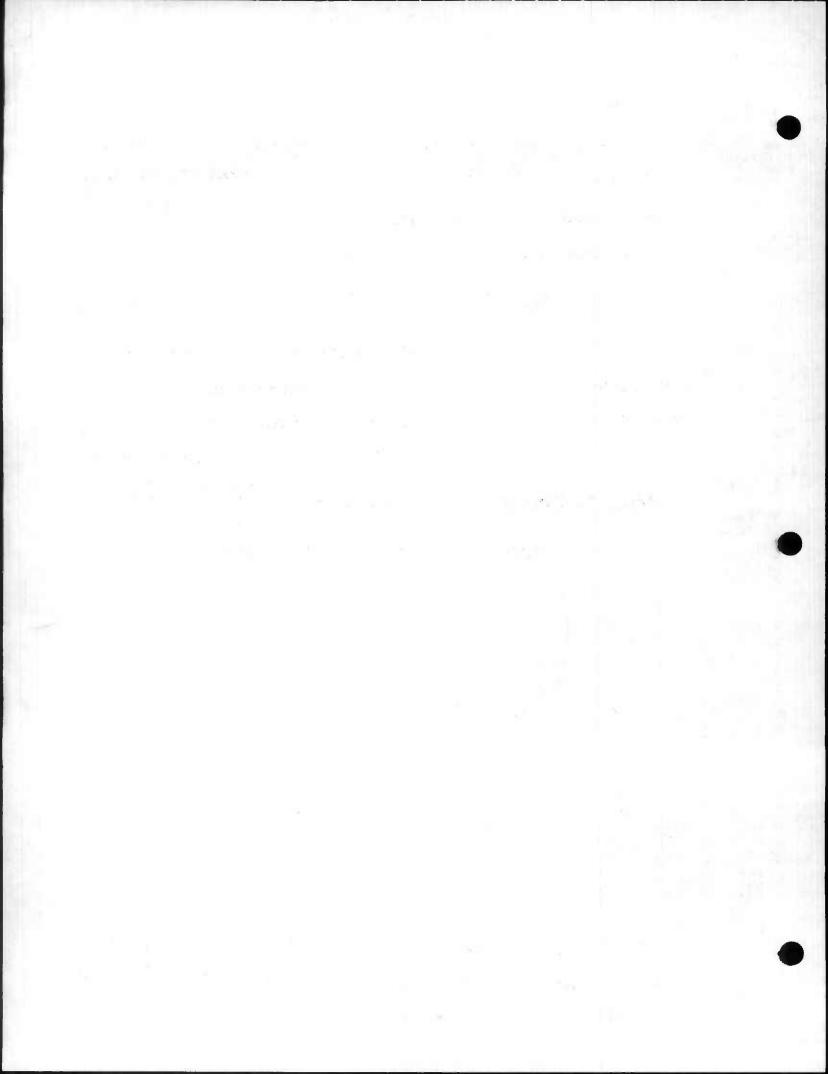
		Decedent's Nama (First, Middla, La	st)		Cei	rtificate of	Death	2. Data of Deet	eg. No. JO	U 0	. Time of Death
Physicia	n	Frances W.	Runke	9				Month	Dey	Yaar	:00am
/Medica Examine	_	4a Facility Nama (If not institution, giv	a street and n	umber)			4b. City, Town, or L		4c. County		· OO CLIN
		Carroll County G	eneral	Hospit	al		Westminst	er	Carrol		
Funeral Director		050 10 5200	Sex I□M 2√F	7. Aga (In yo	rs. last birthday) Yrs.	If Undar 1 Yaar Months Deys		8. Data of Birth (Month, Day, Apr 8	Yaar) 1906	9. Birthplace Country) Missou	(Stata or Foraign
72 hours aftar death with the Maryland natural', or items 23a or 28a-1 show sical Examinal must be nothlad at	-	Usual Rasidanca of Dacedant 10a. Stata 10b. County		10c.	City, Town or Lo	cation				10d.	Insida City Limits
d b	ō	Md Carroll		Syk	esville						1 ☐ Yas 2 📉 No
23a or 28a-f show	ai Director	10e. Street end Number 7200 Third Ave.	B104			10f. Zip Code 21784			0g. Citizen of V ISA	Vhat Country?	
if, or items 2	by Funeral	11. Marital Status 1 Navar Married 2 Married 3 Vidowed 4 Divorced	Armed F	2 No		Was Decedant of If Yas, specify Cul	Hispenic Origin? (S) ben, Maxican, Puarto Specify:	pecify Yas or No- pecify Yas or No- pecify Yas or No-	Blac	e - American I ek, Whita, etc. White	ndian,
	Completed by	15. Decedant's E (Specify only highest gra	ada complated		16a. Dece (Giva lifa.	dent's Usual Occu kind of work done DO NOT usa retin	pation a during most of worked)	king	16b. Kind of Bu	usinass/Indust	ry
Hygiane. ther than	E	Elementery/Secondary (0-12)	Collaga	(1-4or 5+)	rea	ltor			real es	state	
od oth	o Be C	17. Fathar's Nema (First, Middle, Last John Whitter)				18. Mothar's Nan Edna Lee	na (First, Middla, I Montgom		10)	
Due E		19a. Informant's Name/Reletionship (at and Number or Ru				de)
Haalth tem 27 I other tr		Charles Wehland	attorn			Park Ave	e. Ellicot				Ctato
5 = 5		20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Othar (Special		- 01-1-	camatary, crar	Cemeter	aca)	2-13-98	argyle,		State
Department important: It any injury o		21. Signatura of Funaral Sarvice Lice	nsaa		22	2. Nama end Addr	rass of Facility Ha:	ight Fund	eral Ho	me & Cl	nape1
U.2 6 G		Daige Hargh	Her	bert	P.	O. Box	195 Sykesy	ville, M	1.21784		
		23a. Part1. Entar tha disaasa, or com shock, or heert failure. List only	plicetions that one causa on	causad tha de aach iina.	aath. Do not ent	er the moda of dy	ring, such as cardied	or respiratory arr	ast,	Int	proximete arval Between aset and Death
ysician Medical		Immediata Cause (Final	110		01-		21 erst	000			
kaminer		disaesa or condition rasulting in daeth)	a. V Q	Dua to	(or as a consec	quence of):	esyst		-	C	mylond
g physician and as the buriel-transit	ner		. A0	vero	Sele	Thousand	Hear	1 de	Sea	8 5	year
physician and s the buriel-transit	Examiner	Sequentially list conditions,	D (*)	Dua to	(or as a consac	quenca of):					-
		Sequantially list conditions, if any, leading to immediate cause. Entar Undarlying Causa (Disaasa or Injury that initiated evants	c							i	
g phys	edicai	rasulting in death) Last		Dua to	(or as e consec	juence of):					
			d							1	
a atta	Physician/M	Part II. Other significant conditions of	ontributing to	death but not r	asulting in the u	ndarlying cause g	iven in Part I.	23b. Did to	obacco usa co	ptribute to th	e cause of death?
								1 🗆 Y	es 210 No	3 Probab	ly 4 Unknown
bed .	P							24e. Wes e	n outono:	24h Wara	autopsy findings
peen s	Completed							perfor		eveita	bte prior to ation of cause
hes ya 2	E E							1□ Y	es 2IDNo	of das	as 2 No
		25. Wes case referred primedical					26 Place of Des	ath (Check only or		101	as 20140
40 100	o Be	axaminar?	Hospital:	Mnpatient 2	ER/Outpatier	nt 3 DOA O	ther	loma 5 ☐ Rasid		er (Specify)	
h. After thi funaral	ation: T	27. Manner of Death 1 Waturel 5 Panding 2 Accidant invastigation	(Mo	a of Injury onth, Day Year	28b. Tima o Injury	W	ury at ork?	28d. Dascribe h	ow injury occur	red	
within 24 hours after daeth. To the Funeral Director: After complataly filled in by tha funa	Certification:	3 ☐ Suicida 6 ☐ Could not be detarmined	28a. Plac	ca of Injury - A ding, atc. (Spe		reet, factory, office	9	28f. Location (S City or Tow		per or Rural R	outa Number,
within 24 hours after To the Funeral Dir compiataly filled in	edicai	29a. Certifier (Check only one) 1 Cartifying Pt 2 Medical Exam	miner: On the	na bast of my le basis of exami nnar stated.	nowledge, deet ination and/or in	h occurrad at the vestigetion, in my	time, date and placa opinion, death occu	, and dua to tha c rred et the tima, c	ausa(s) and ma lata and place,	anner as state end dua to the	od. a causa(s)
To th comp	×	29b. Sign Ture and title of certifier				29c. Licar	nsa number	2	9d. Data signa	d (Month, Day	v, Year)
		Chilqululu	Not	amo	9	DI8	5200		219	198	
	1	30. Name and addrass of person who	complated ca								
		CHITRACHEDU NAG	N HOW	170 CH	OA PO	DUE RE	westn	MNSTER	1 MD	2115	1

Registrar

31. Data filed (Month, Day, Year) FEB 13 1998 32. Registrar's Signature



DL .		Decedent's Neme (First, Middle, La	net1	(Certificate of	Death	2. Date of Dea	Reg. No.	3. Time of Death
Physici /Medi		Merle	131/	Rine	r		Feb. 8,	Dev	1:05 A.M
Examir		4e. Facility Name (If not Institution, gire	ve street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death
Funeral		5. Social Security Number 6.	1 DM ODE	n yrs. last birth	day) If Under 1 Year Months Devs		8. Date of Birt (Month, Da		9. Birthplace (State or Fore
Director		233 10 3294 Usual Residence of Decedent	87	Yı	S.		August	16, 191	0 W.Va.
show ad at		10a. State 10b. County	10	Oc. City, Town	or Location				10d. Inside City Lim
the Mar 28s-f sh	ctor	Md. Carroll	_ 0	Sykesvi	lle				1 Yes 2
with a or	i Director	10e. Street end Number 7309 Second	Ave.		10f. Zip Code 21784			10g. Citizen of W	/hat Country?
after dea or items miner m	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	or In U,S.	13. Was Decadent of I	oan, Mexican, Puerto	pecify Yes or No-	14. Race Black	- American Indian, k, White, etc. White
within 72 hours jiene. r than "natural",		15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. D	ecedent's Usual Occu	pation during most of work	king	16b. Kind of Bu	siness/Industry
of filed within of Hygiene. I other than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		He. DO NOT use retire dical assi	*		health	care
be filed tel Hygi d other ovent,	Be	17. Father's Name (First, Middle, Last	")			18. Mother's Nam	ne (First, Middle,	Maiden Sumam	θ)
should be nd Mentel marked o	2	Carl F. Cole					Meadows		
h end less me		19a. Informent's Neme/Relationship			Meiling Address (Street				State, Zip Code)
s 1 and 2 should be filed if Heelth and Mentel Hyg Item 27 Is marked othe other traumatic event,		20a. Method of Disposition		20b. Placa of D	Box 44 We disposition (Name of	T	Md. 21		City or Town, State
permit. Pages 1 en Department of Heel Important: If Item 2 any injury or other once.		1 XBurial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery,	crematory or other pla dge Memoria	al 2	/12/98]	Prosperi	ty, WV
Depart Import any in		21. Signeture of Funeral Service Lice	nsee Lindy	ess of Facility Haig	ht Fune	cal Home			
		23a. Part1. Enter the disease, or conshock, or heer failure. List only	plications that caused the	e death. Do no	P.O.Box 19	95 SYKES Ing. such es cardiec	VIIIe, I	Ad. 2178 rest,	Approximate Intervel Between
Physician /Medical Examiner	ler	Immediate Ceuse (Final disease or condition resulting in death)	a. Atheros	e to (or as a co		.0 . 4.4	Vuscal.	Oise.	Onset and Death
Mecuted n end al-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Du	e to (or as e co	nsequenca of):				
cermicate be executed adding physicien and use es the burial-transit	edicai	Cause (Disease or injury that Initiated events resulting in death) Last	C. Due	e to (or as a co	nsequence of):				
e attending	Physician/M	Part II. Other significant conditions		ot resulting in t	ne underlying cause gi	ven in Part I	23h Didi	obacco usa con	tributa to the cause of de
by th	Phys	Alzhainen	Denen,	1	re underlying cause gr	VOIT III PAIL I.			3 □ Probably 4 □ Unkn
ed plant	Completed by							an autopsy rmed?	24b. Were autopsy findin available prior to completion of cause of deeth?
JL (1)	E O						101	es 2 PNo	1 ☐ Yes 2 ☐ No
has t									
ate has t	Be	25. Was case referred to medical				26. Place of Dea	th (Check only o	ne)	
ate has t	To Be	exeminer? 1 ☐ Yes 2 ☑ No		2□ER/Outp	atient 3LI DOA	her: 4 Nursing H	ome 5 Resid	lence 6 Othe	
this certificate has that director, page 2 s	၉	exeminer?	28a. Date of Injury (Month, Day Ye	28b. Tin	ne of 28c. Inju	her: 4 Nursing H	ome 5 Resid		
this certificate has t	၉	exeminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Tin	ne of 28c. Inju	her: 4 Nursing H	ome 5 ☐ Resid 28d. Describe t	lence 6 □Other now Injury occurre	
this certificate has that director, page 2 s	Certification: To	exemlner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined. 29a. Certifier 1 Certifying Prince 1	28a. Date of Injury (Month, Day Ye 28e. Placa of Injury	28b. Tin Inji At home, farm Specify)	attent 3L DOA te of	her: 4 Inversing Herry at trk? Yes 2 No	28d. Describe to 28f. Location (\$\frac{City or Tov}{C}\$ and due to the	dence 6 Other own Injury occurred Street and Numbern, State)	er or Rural Route Number,
this certificate has that director, page 2 s	၉	exemlner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signeture end title of cartifier	28a. Date of Injury (Month, Day You building, etc. (5) 28e. Placa of Injury building, etc. (5) 28e. Placa of Injury building, etc. (6)	28b. Tin Inju	le of many Many Many Many Many Many Many Many M	me, dete and placa, opinion, death occurs se number	28d. Describe to 28d. Location (\$\frac{City or Tow}{Cred et the time, to 28d. Constitution of the constitu	dence 6 Other now injury occurred on Number of	er or Rural Route Number, nner as steted. ind due to the ceuse(s) Month, Day, Year)
ate has t	edical Certification: To	exeminer? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signeture end title of cartifier 29b. Name end eddress of person who	28a. Date of Injury (Month, Day You building, etc. (5) 28b. Placa of Injury building, etc. (5) aysician: To the best of miner: On the basis of examplement of the basis of examplement of death of the basis of death of the basis of death of the basis of death of the basis of death of the basis of death of the basis of death of the basis of death of the basis of death of the basis of death of the basis of death of the basis of death of the basis of death of the basis of death of the basis of death of the basis of the bas	28b. Tin Inju	ne of per per per per per per per per per per	me, dete and placa, opinion, death occurs se number	28d. Describe to 28d. Location (\$\frac{City or Tow}{Cred et the time, to 28d. Constitution of the constitu	dence 6 Other now injury occurred on Number of	er or Rural Route Number, nner as steted. ind due to the ceuse(s) Month, Day, Year)
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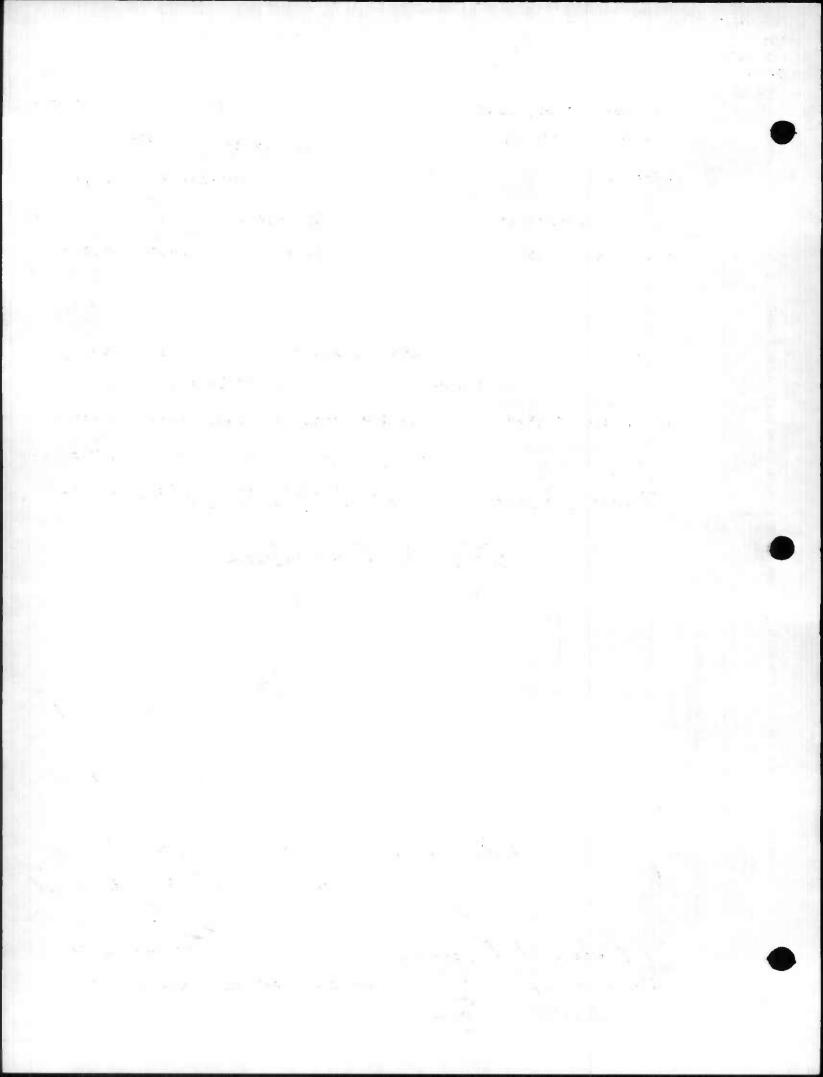
98-0596-019 jhm MIKE ANTHONY

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State of Maryland / Department of Health and Mental Hygiene

06616

MITH						Cer	lincale of	Deam		Reg. No.		0010
Physic /Med			ne (First, Middle, Li el Antho	_{ası)} ony Smith)				2. Dete of D Month FEBRU	ARY 08,	1 ^{Yeer} 1998	3. Time of Death 03:15 AM
Exami		4a Fecility Neme		ve street end number)				4b. City, Town, or			of Death	ER
Funeral Director		5. Social Security P	8260	Sex 7. Ag 1以M 2□F	ge (In yrs. lest 3 (birthdey) Yrs.	If Under 1 Year Months Deys		8. Date of B (Month, L		9. Birth	place (Stete or Foreign ntry)
pue *-		Usual Residence of	10b. County		10c. City, T	own or Loc	ation					10d. Inside City Limits
Aenyl	ō	MD		nester				Rhodesd	lale			1 ☐ Yes 2 No
the the	Director	10e. Street and Nu		163661			10f. Zip Code	11110000		10g. Citizen of	Whet Cou	ntry?
ath with the Meryler 23e or 28e-f ehow	D	4314 M	lessick	Road				21659		Unite		
leath	era	11. Maritel Stetus	1000101	12. Was Decedent	Ever in U,S.	13. V	Vas Decedent of	Hispenic Origin? (S ban, Mexican, Pue	Specify Yes or N	lo- 14. Ra	ce - Ameri	can Indien,
15-UUZU 72 hours after death with the Meryland *naturel', or frame 23s or 28s-f show sides! Exercises must be notified as	by Funeral		rled 2 Married	Armed Forces? 1 Yes 2 II If Yes, Give Yeer or Dates:			Yes, specify Cut ☐ Yes 2 No		rto Rican, etc.)	Specif	ck, White,	etc. ack
2 hou	be		15. Decedent'a E	Education	1	6a. Deced	ent's Usual Occu	pation		16b. Kind of B	usiness/in	dustry
ZTS	Completed		cify only highest gr		E.)	(Give I	kind of work done OO NOT use retire	during most of wo	orking			
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DIVISION O To the Hospital or Attending Ph within 24 hours effer death. To the Fureral Director: Affer thi completely filled in by the funeral	edical	29a. Certifier (Check only one)		hysician: To the best miner: On the basis o and manner st	f examination							
Vithin Vithin	Me	29b. Signature and	d title of certifier				29c. Licer	nse number		29d. Date sign	ed (Month	Day, Year)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Charles Joseph Simpson 6 98 2 Por 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Carroll County General Hospital Westminster Carroll If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yaar Birthplaca (State or Foraign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days 1 M 2 □ F Yrs. 356-10-3845 77 June 25, 1920 Illinois Usual Rasidenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Westminster 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 817 William Avenue 21157 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14 Race - American Indian Black, White, etc. 1 X Yes 2 No It Yes, Give Year or Dates: ↓ 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White WWII 16b. Kind of Business/industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade complated) College (1-4or 5+) Elementary/Secondary (0-12) Register of Wills County Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Fethar's Nama (First, Middle, Last) Charles Simpson Elva McBride 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Intormant's Name/Relationship (Type, Print) Marjorie Simpson, wife 817 William Avenue, Westminster, MD 21157 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 02/20/98 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State Meadow Branch Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Westminster, MD 21. Signature of Funeral Service Licenses 22 projects Address Frail Home & Chapel 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that causad the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart tallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC 15 MIN ARRHYTHMIA Due to (or as a consequence of): PLUTE MYOCARDIRL Due to (or as a consequence ot): INFARCTION CORONORY HEART DISEASE ATTHEROSCIEPOTIC Dua to (or as a consequence ot): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknow 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

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director

The law requires that the death certificete be executed

or Attending Physician:

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Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Certification:

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Physician

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an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Men

with the Merylend

Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case reterred to medical 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of t Natural 5 Pending

Investigation

6 ☐ Could not be

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

2 Accident 3 Suicide

29c. License number

29d. Date signed (Month, Day, Year)

elex 30. Name and address of person who completed cause of death (Item 2%) (Type, Print) 201663

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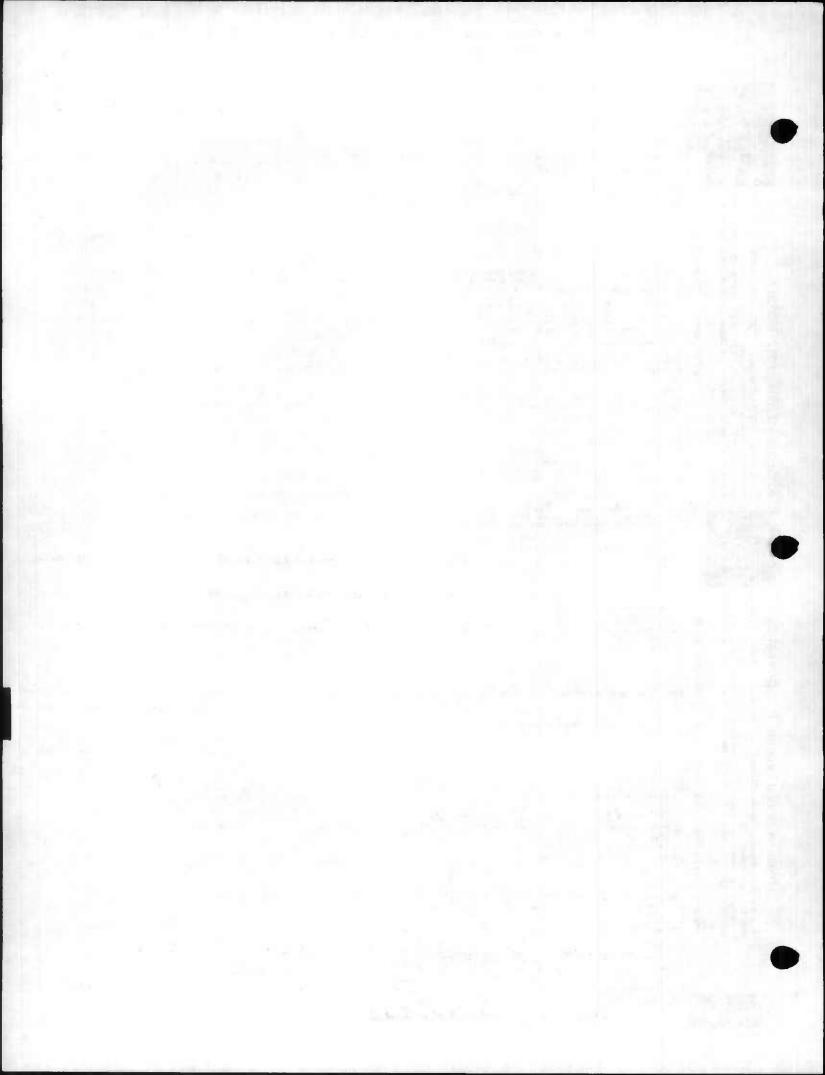
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10000 31. Date tiled (Month, Day, Year) 32. Registrar's Signature

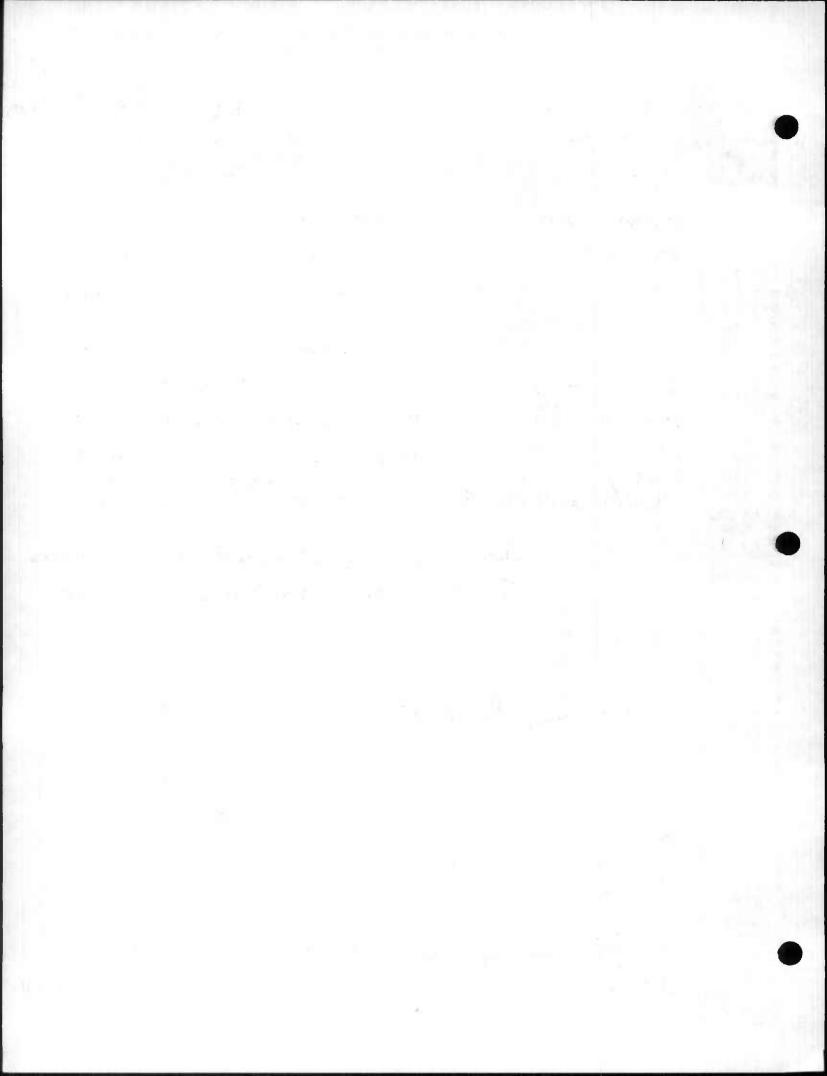
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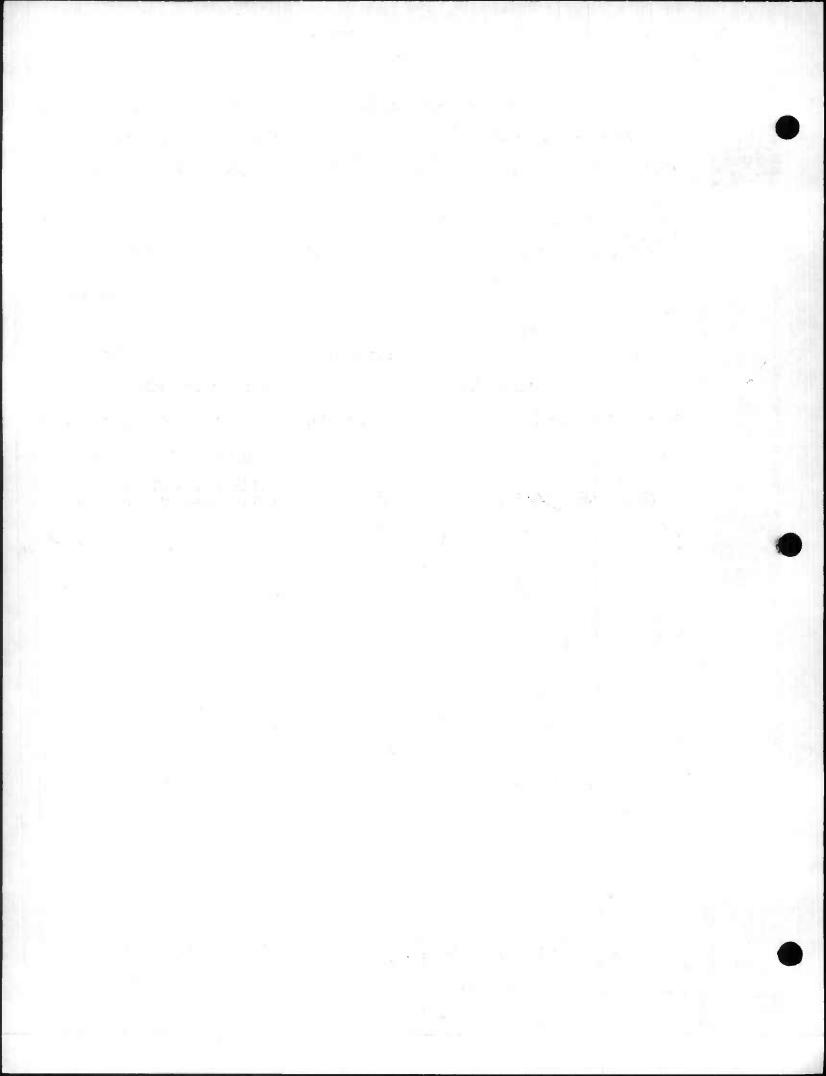


State of Maryland / Department of Health and Mental Hygiene Q

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		-	Decedant's Nama (First, Mi	ddla, Last)		С	ertificate	of	Death		2. Data of Da	Reg. No.	b u	3. Time of	Death
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	a-f sh	ctor	MD Car	roll		Taneyt	own							1 🗌 Yas	
	th with the 23a or 28 unt be no	al Director	10e. Street and Number 4857 Rugg.	es Road			10f. Zip (Coda	2178	7		10g. Citizan of U.S		ntry?	
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Ammended Harford County Health Dept. Line #1 2/19/98 KDG Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedeni's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Day Frances Coon Schreiber Frances Ray Schreiber 02 12 1998 10:12 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 217 Tidewater Drive Havre de Grace Harford 5. Social Security Number If Under 1 If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 XF Yrs. Director 10/29/1944 249-70-9404 53 Usuai Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural" any fullury or other traumetic events. 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Director MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 217 Tidewater Drive 21078 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 Yes 2 No þ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be P Francis Coon Rae DeMars 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Henry Schreiber- Husband 217 Tidewater Dr., Havre de Grace, MD 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park Cemetery 2/16/98 Orangeburg, SC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A.

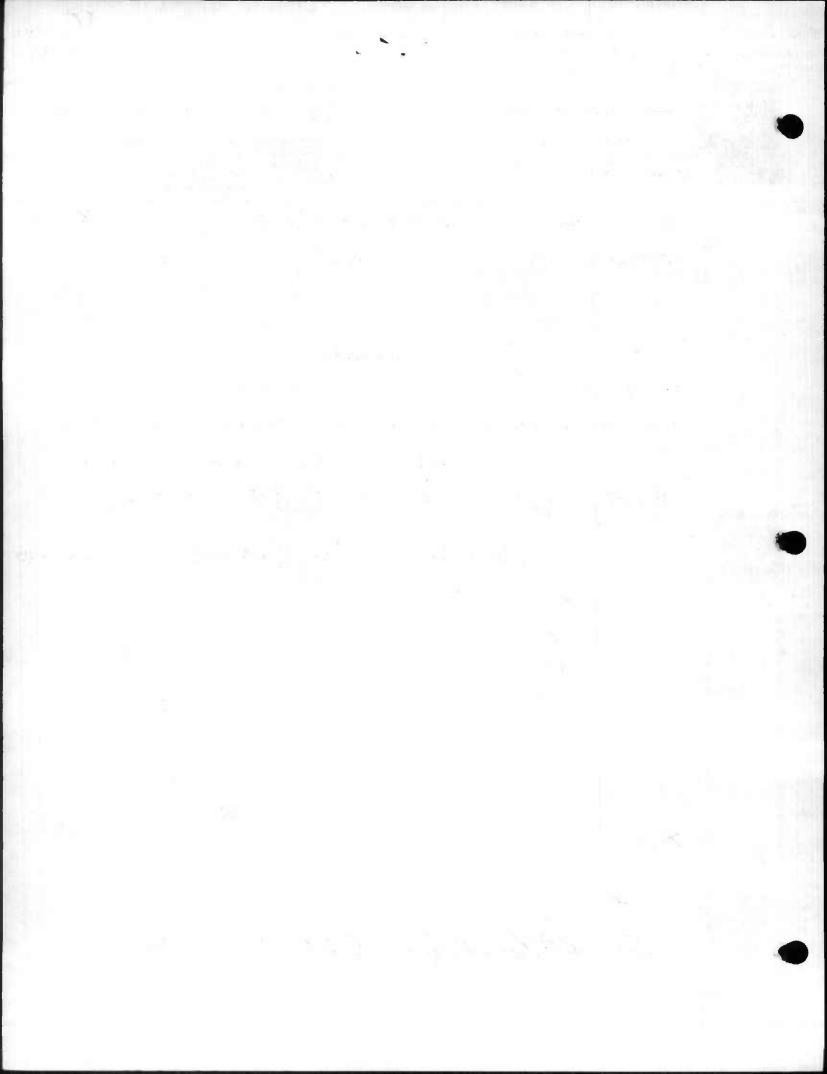
123 S. Washington St Havre de Grace, MD

23a. Part Enter the disease, or complications that caused the deeth. Do not exter the mode of dying, such as cardiac or respiretory errest,

Approximate Approximate Intervel Between Onset end Death **Physician** METASTATIC Colon CANCER /Medical immediate Cause (Final 20 months disease or condition resulting in death) Examiner Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequenca of): Box 68760, been signed by the attending physician should be detached for use es the buria Physician/Medical Due to (or es e consequenca of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the causa of death? 2 No 3 Probably 4 Unknown 1 Yas Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause of death? this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. injury at Work? After Neturai 2 Accident 5 Pending investigation 1 Yes 2 No death. after death Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) yd ni bellif 4 - Homicide To the Hospital of within 24 hours a To the Funeral Completely filled in the Funeral Completely fin edical Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filed (Month, Day, Yeer) 1998 32. Registrar's Signature State Registrar

DHMH 16 Rav 6/95

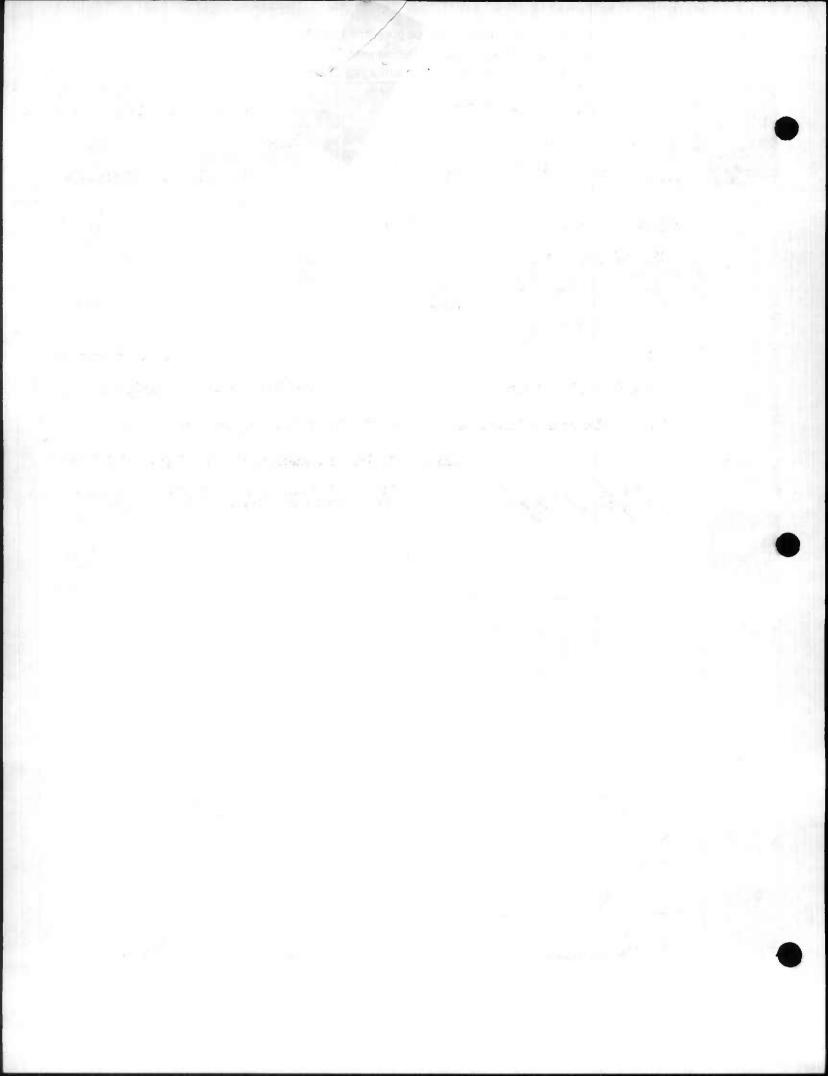


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** RALPH LYLE February 11, 1998 8:15 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1413 Old Joppa Rd. Joppa Harford If Under 1 Yaar If Under 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Dafa of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Days Hours 1⊠M 2□ F Yrs **Director** 230-20-0040 May 22, 1925 Virginia Usual Rasidenca of Decedant Peges 1 and 2 should be filled within 72 hours efter death with the Maryland nent of Health and Mental Hyglena. r 28a-f ehow 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo Maryland Harford Joppa 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examinar must be 1413 Old Joppa Rd. 21085 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Black, Whita, atc. Amed Porces of 1 1 2 yas 2 No WWII If Yas, Giva Yaar or Dates: Korean 1 Never Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Cook U. S. Government 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be (nmn) Samuel (u/k) Smith Buelah Gillispie 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) permit. Peges 1 and 2 s Department of Health ar Important: if Item 27 is any Injury or other trau 1413 Old Joppa Rd., Joppa, Md. Linda L. Zaremba - Daughter 21085 20b. Place of Disposition (Name of camatary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from Stata Trinity Lutheran Cemetery2-14-98 4 ☐ Donation 5 ☐ Othar (Specify) Joppa, Maryland 22. Nama end Addrass of Facility 22. Nama end Addrass of Facility
Howard K. McComas III Funeral Home, P.A

Bel Air, Md. 21014 50 W. Broadway St., Bel Air, Md. 23a. Part I. Enter the disease, or complicate shock, or heart failure. List only one complicate shock in the complete shock in the c stons that caused the daath. Do not anfar the mode of dying, such as cardiac or respiratory errast, causa on each line. Approximate Interval Batween Onsaf end Deeth Physician /Medical Immediata Cause (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Mellitus physician and the burial-transit law requires thet the death certificate be axecuted Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of):\ Physician/Medical Dua to (or es a consequance of) ettending | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. been signed by the should be datached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to complation of cause of daath? 24a. Was an autopsy performed? Completed has paga 2 After this certificata 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was casa rainred to medical Be 28. Placa of Death (Check only ope) axaminar? Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 0 1 Yas 2 No 1 | Inpatiant 2 | ER/Outpatiant 3 | DOA filled in by the funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of Certification: 5 Panding invastigation 1 Natural To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A 1 Yas 2 No 2 Accidant 6 Could not be datamined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straaf, factory, offica building, atc. (Specify) 4 Homicida Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifian Medical (Check only one) 29b. Signatura and title of certifiar 29c. Licansa number 29d. Data signad (Month, Day, Yaar) 30. Nama and addrass of person who complated causa of death (Itam 23a) (Typa, Print) 132. Registrar's Signatura 31. Data filad (Month Pay, Yaar) 1998 State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month MARY JANE SMITH 12 P.M. February 18, 1998 /Medical 4e. Facility Name (If not institution, give street end numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 56 Little Creek Lane Edgewood Harford 7. Aga (In yrs. last birthday) Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number Birthpleca (Steta or Foreign Country) **Funeral** Days 1 ☐ M 2 🖸 F Yrs Director 236-40-8258 69 July 19, 1928 West Virginia Usuel Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Maryland Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 56 Little Creek Lane 21040 USA death 12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "natural", or frem any Injury or other traumatic event, the Medical Experimentance. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 56 Little Creek Lane, Edgewood, Md. Roland L. Smith - Husband 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 St Burlal 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion U. M. Cemetery 2-21-98 Bel Air, Maryland 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. tion that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, and a ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, and a ceused the deeth. Approximete Interval Between Onset and Deeth Physician ARCINOMA LUNG /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner signed by the attending physician and die detached for use es the burial-transit be executed Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 10 Yes 2 No 3 Probably 4 Unknown CHONONIC ZUNL DISIGNE Records, à sete has been signated page 2 should b 24b. Were autopsy findings evellable prior to completion of ceusa of deeth? Completed 24a. Was an eutopsy performed? this certificete has 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 ☐ Yes 2 ☐ No To funerei 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After Attending 5 Pending investigation 1 Natural deeth. 1 ☐ Yes 2 ☐ No spital or Attendi tours after deeth neral Director: A 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicide Hospital c To the Hospital within 24 hours a To the Funeral C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) end manner es steled.

2 Medical Examiner: On the besis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of Centre 29c. License number 020390 raileo Nullin 9 30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print)

32. Pogistrats Signature

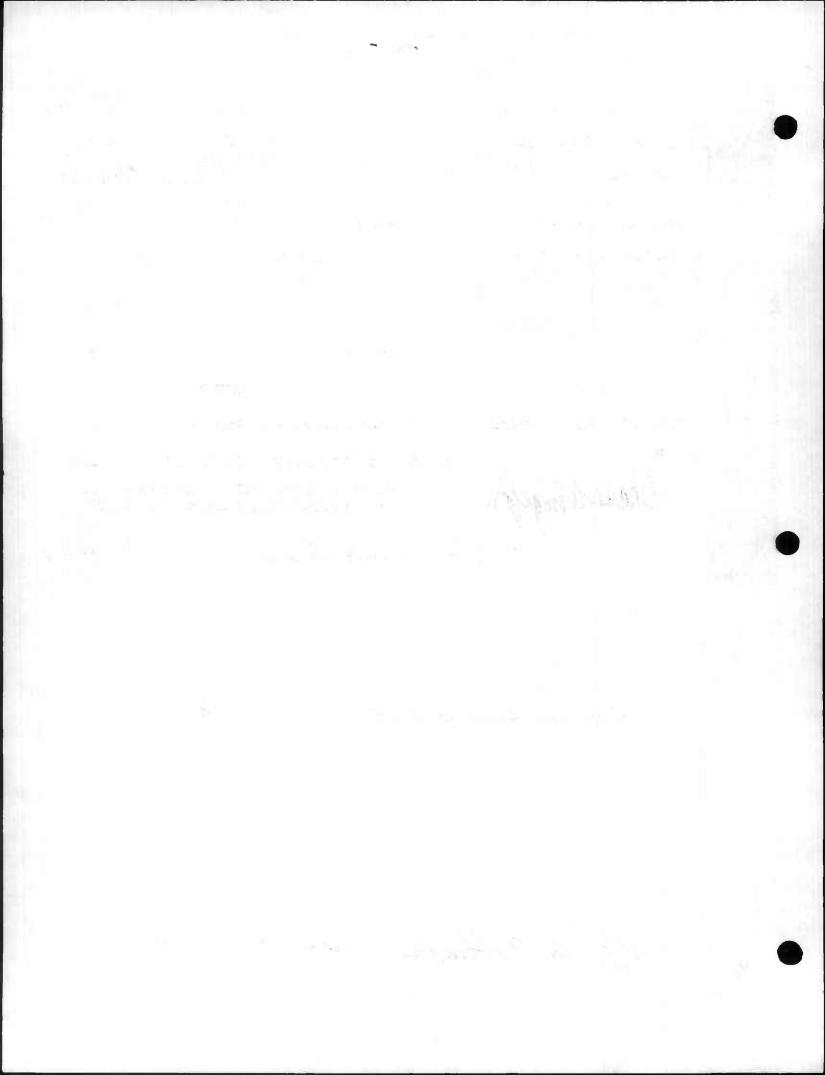
DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Dey, Yeer)

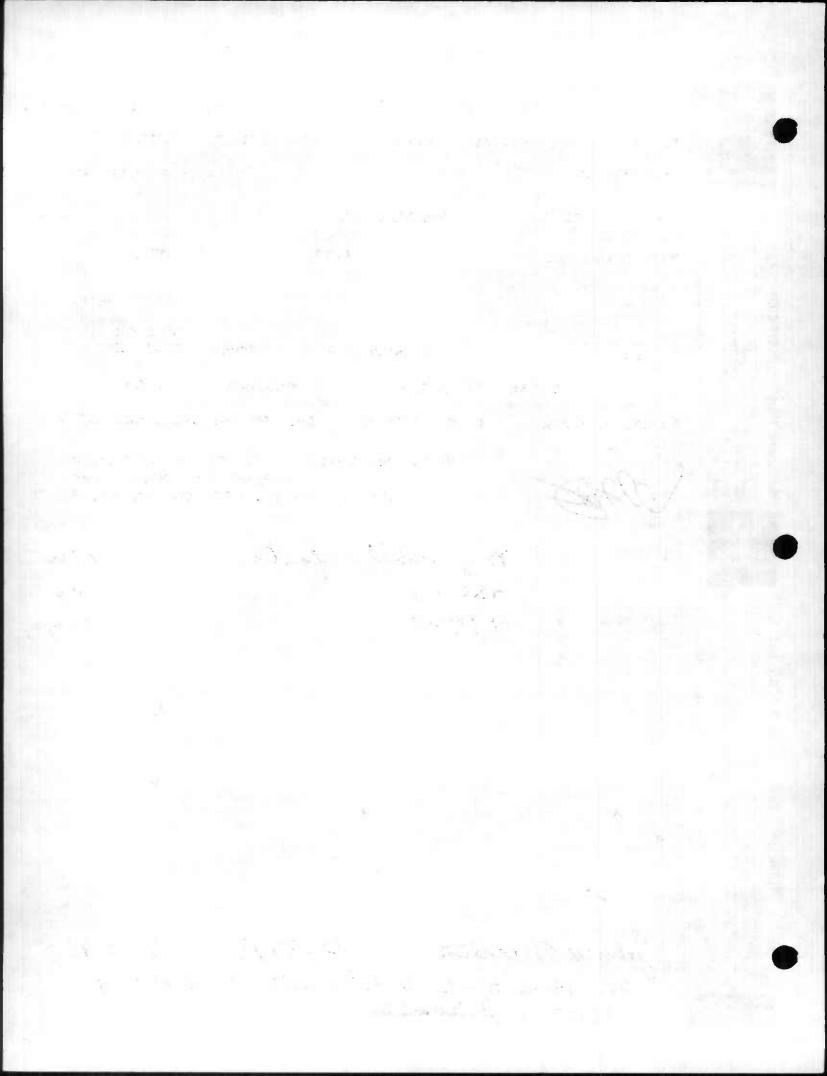
FEB 2

0 1998



	State of Maryland / Department of Health and In Certificate of Death		No.98	06623
Physician /Medical	1. Decedent's Name (First, Middle, Last) ANNA JANE TAYLOR	FEB. 14	1, 1998	6:11 PM.
Examiner	4a Facility Name (If not institution, give street end number) CARROLL COUNTY GENERAL HOSPITAL WESTMIN		4c. County of I	
neral ector	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Dete of Birth (Month, Day, Yo 9 / 1 1 / 1 9		Birthplece (State or Foreign Country) ARYLAND
N	Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
by Funeral Director	MD. CARROLL WESTMINSTER			1 ☐ Yes 2 No
Dire	10e. Street and Number 10f. Zip Code	10g.	. Citizen of Whe	et Country?
Fal	2215 RIDGE RD. 21157		USA.	American Indian,
by Funeral Director	11. Maritel Status 12. Was Decedent Ever In U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent of Hispenic Origin? (Signer of Signer) (Signer of Signer) (Signer of Signer) (Signer of Signer) (Signer of Signer) (Signer of Signer) (Signer of Signer	Rican, etc.)		White, etc.
		later en	b. Kind of Busin	
Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) (Give kind of work done during most of work life. DO NOT use retired)		OUTDOO!	
	12 SECRETARY & BOOK KE	EPER I	EQUIPM	ENT
Be			BLUM	
P _O	19a. Informant's Name/Retationship (Type, Print) 19b. Mailting Address (Street end Number or Ru			
	ROBERT D. TAYLOR -HUSBAND 2215 RIDGE RD., WE	ESTMINST	ER, MD	. 21157
To Be Completed	20e. Method of Disposition 20b. Place of Disposition (Name of	Date 20	c. Location - Cit	ty or Town, Stete
	1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) METRO CREMATORY 2	16/98 B	BALTIMO	DRE, MD.
8500	22. Name end Address of Facility FL 254 E. MAIN ST.			
Physician/Medical Examiner	disease or condition resulting in death) e. Grue to (or es e consequence of): b. Due to (or es a consequence of): t any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initileted events resulting in death) Lest Due to (or es e consequence of): t. Due to (or es e consequence of): d.			10g Zoyr
by Physici	Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Dfd toba	icco use contri	ibute to the cause of death?
		1 ☐ Yee	20 No 3	Probably 4 Unknown
eted		24e. Wes en e		24b. Were eutopsy findings evalleble prior to completion of cause of deeth?
Сотр		1 ☐ Yes	2.00 No	1 ☐ Yes 2 ☐ No
Be C	25. Wes case referred to medicet exeminer?	oth (Check only one)		
completely filled in by the funeral director, par Medical Certification: To Be Co	1 Yes 2 No	ome 5 Residence 28d. Describe how 28f. Location (Stree City or Town, 5	Injury occurred	
Cert				
edical	29e. Certifier (Check only one) 12 Cartifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end place (Check only one) 13 Cartifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end place (Check only one)	rred et the time, dete	end plece, end	d due to the cause(s)
completely filled	29b. Signeture end title of certifier 29c. License number	290		Month, Day, Year)
	John W. On weddelin 12 44	3		16-98
	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Totto (688 Poole Road Wistminster)	mid	2115	7
State	31. Dete filed (Month, Day, Yehr) FEB 1 7 1998 32. Registrer, Signature 32. Registrer, Signature			

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate of	Death		Reg. No.	98	05521
	Physici		1. Decedent's Name (First, Middla, Les Grace Tayl	,					2. Date of De Month Feb	11 ^{Dey}	1998	7:15am
	/Medic Examir		4e. Fecility Neme (If not institution, give 3402 Offutt Road					4b. City, Town, or I	Location of Deet	th 4c.	County of Dee	oth
	Funeral Director		Social Security Number 6. Security Number		e (In yrs. last b	irthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs.	8. Date of Bi	rth	9. Bir	rthplace (State or Foreign
Maryland	r 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Howard		10c. City, Tov	wn or Lo	cation City					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
h with the	3a or 28	Funeral Director	10e. Street and Number 4209 College Avenu	le			10f. Zip Code 210	43		10g. Citi USA	zen of Whet C	ountry?
5-0020 72 hours after death with the Maryland	al', or items 23a or Examiner must be	by	11. Marital Status 1 Never Married 2 Married X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Yeer or Detes:			Vas Decedent of Yes, specify Cu I ☐ Yes 2 ☐ No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecity Yes or No o Rican, etc.)		14. Race - Am Bleck, Whi Specifywhi	ite, etc.
21215-0020 d within 72 hours af	jena. r than "natural", the Medical Ext	eted	15. Decedent's Ed (Specify only highast gra	ucation da complated)	16a	Deced (Give	lent's Usual Occu	upetion a during most of wor ed)	rking	16b. Ki	nd of Business	s/Industry
d 2121		ошо	Elementary/Secondary (0-12)	College (1-4or !	5+)	he. L	ox stri	pper		mar	ufactu	ring
77 -	and Mental Hygis is marked other raumatic event, II	To Be Completed	17. Father's Neme (First, Middle, Last) James Perry		.,,			18. Mother's Nan Nancy R		, Maidan	Sumama)	
	aith and N 27 is ma er trauma		19a. Informant's Name/Relationship (7) Rethea E. Foster	, , ,				at and Number or Rud. Randal				Zip Coda)
nou	t: If If		20e. Method of Disposition 1 → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removel from State	cemate	ary, cran	sition (Name of natory or other plo n Memori	al 2	Dete -14-98		cation - City or	Town, State
Baltir P	Departr Importa any inju		21. Signeture of Funeral Service Licenters Page Should		-		Name and Add	ress of Fecility H 195 Sykes				& Chapel
/N	ysician Medical aminer	er	23e. Part1. Enter the disease, or comp shock, or heert failure. List only of Immediate Ceuse (Final disease or condition resulting in deeth)	lications that caused in e ceuse on each li		a	· lur		c or respiretory e	errest,		Approximete Interval Between Onset and Deeth
Box 68760, ath certificate be assecuted	nding physiclan and use as the burial-transit	by Physician/Medical Examiner	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	b	Due to (or es a							
P.O.	been signed by the attendin should be detached for use	by Physicia	Pert II. Other algnificent conditions co	sul,				iven In Part i.		tobacco Yes 2		e to the cause of death?
(1)	s been si 2 should	Completed	Chanic	lung	D150	~	e		24a. Was	en eutop ormed?	sy 24b.	Were eutopsy findings available prior to completion of cause of death?
al Rec	cata ha								1□	Yes 2	SNO	1 ☐ Yes 2 ☐ No
Vital	certifi	o Be	25. Was case referred to medical examiner?	Hospital:	AD 50/0		0	26. Plece of Dee	1			
Vision of Vita	n. Aftar this funeral d	tion: To	27. Manner of Deeth 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Inju (Month, Day		Time of Injury	28c. Inju	4 LI Nursing n	ome 5 Resi 28d. Describe			acity)
Division	Director	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Plece of Injuding, etc.	ury - At home, fa c. (Spacify)	arm, stre	eet, factory, office		28f. Location (City or To			lural Routa Number,
To the Hospital or	within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Phy	alcian: To the best of ner: On the besis of and manner sta	examination er	e, death nd/or Inv	occurred et the t estigation, In my	ime, dete and place opinion, deeth occu	, and due to the rred at the time,	ceuse(s) date end	and manner a place, end du	s stated. e to the cause(s)
Tott	To the company	×	29b. Signature end title of certifier	Coop	me	2		ese number		29d. Date	e signed (Men	th, Day, Year)
	Sta Registra		Name and address of person who control of the state of th	nick M	eath (Item 23e)	20	2001	berety	Rka	AND	AUSTO	wid 21133

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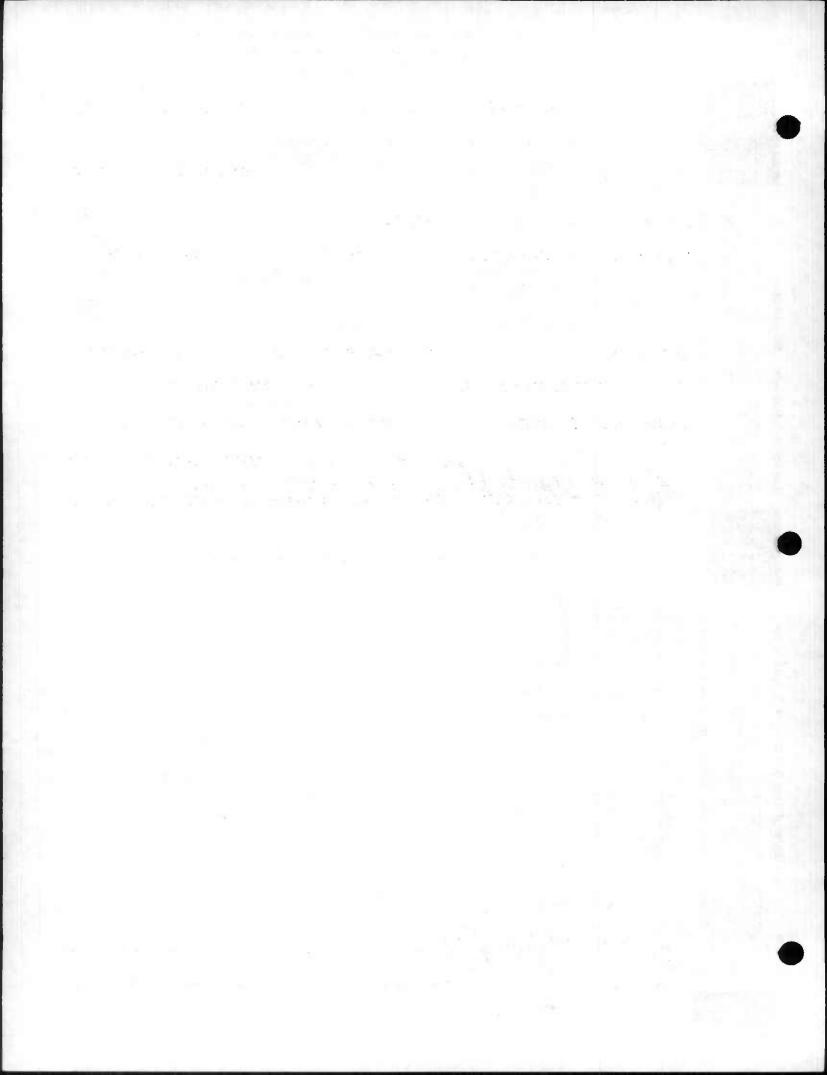
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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death Reg. No. POUND Dey 1. Decedant's Neme (First, Middle, Last) 2. Date of Death Month 10:20 AM Physician MCKINLEY THOMAS JR. WILLIAM 17, 1998 FEBRUARY /Medical FOUND. 4b. City, Town, or Location of Deeth 4a. Facility Nema (If not institution, give street end number, 4c. County of Death Examiner ROAD APT # 8 CITY BLADENSBURG COTTAGE PRINCE GEORGES 3712 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dev. NOV • 28 5. Social Security Number Sex XXM 2□ F 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Months Deys Hours MARYLAND Yrs. 1936 217-30-0192 61 Director Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at Yes 2 No Director MARYLAND PRINCE GEORGE COTTAGE CITY 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? with 3712 BLADENSBURG ROAD APT. #8 20722 UNITED STATES death v Funeral 12. Was Decedent Ever in U,S. Armed Forces? XXXes 2 □ No If Yes, Give Yeer or Detas: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 2 should be filed within 72 hours efter and Mental Hygiene. s marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Merried 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. ģ 3€Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) CONSTRUCTION 12TH GRADE CONSTRUCTION LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be EMMA GUTRICK THOMAS WILLIAM MC KINLEY THOMAS. SR. 2 permit. Pages 1 end 2 sh Department of Health and Important: If item 27 is m any Injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) CHAUNFY MASON / DAUGHTER P.O. BOX 395 LANDIS, NORTH CAROLINA 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHARLES CEMETERY 2/21/98 GLYMONT, MARYLAND 21. Signature of Funeral Service Jugatese 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A. THORNTON JOHNSON M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. TYPIA 20640 23e. Pert1. Enter the disease, or complications thet caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or haart tailura. List only ona cause on each line. Approximate Interval Betw Onset end Death **Physician** /Medical fmmediate Cause (Final disease or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence of) Examiner ician and burial-transit Sequentially list conditions, if any, leading to Immediate causa. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760 the attending physician 9 Physician/Medical the Due to (or as e consequence of): as 950 ó Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by 1 | Yes 2 | No 3 | Probably 4 | Unknown ABUSE ETHANOL δ 2 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to Completed peen completion of cause of death? has 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpafient 2 ☐ ER/Outpatienf 3 ☐ DOA funeral 28a. Date of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be detarmined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homleide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and maintened as seemed.

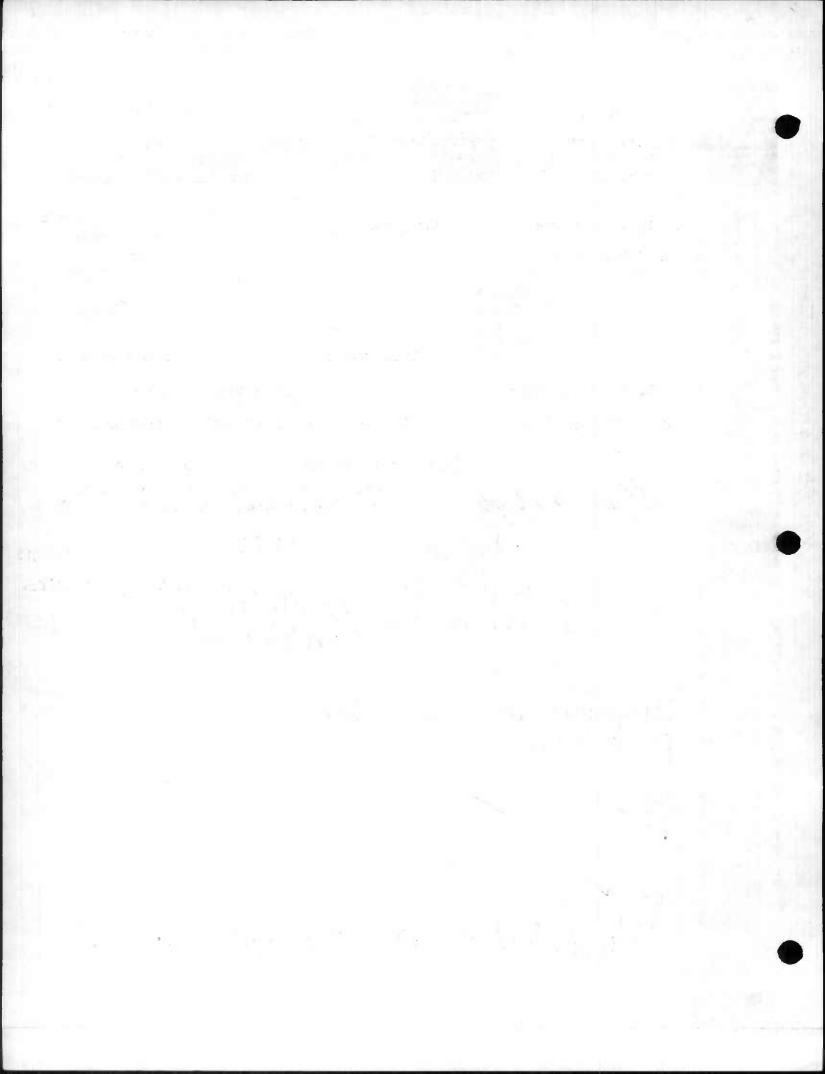
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. 29a. Certifier Medical (Check only one) within 2 To the å, 29c. License number 29d. Date signed (Month, Dey, Year) 2 DME FEBRUARY 19 1998 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print) CHEVERLY, 3001 HOSPITAL DRIVE MD MARYLAND GOLLE MARIO 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar



John

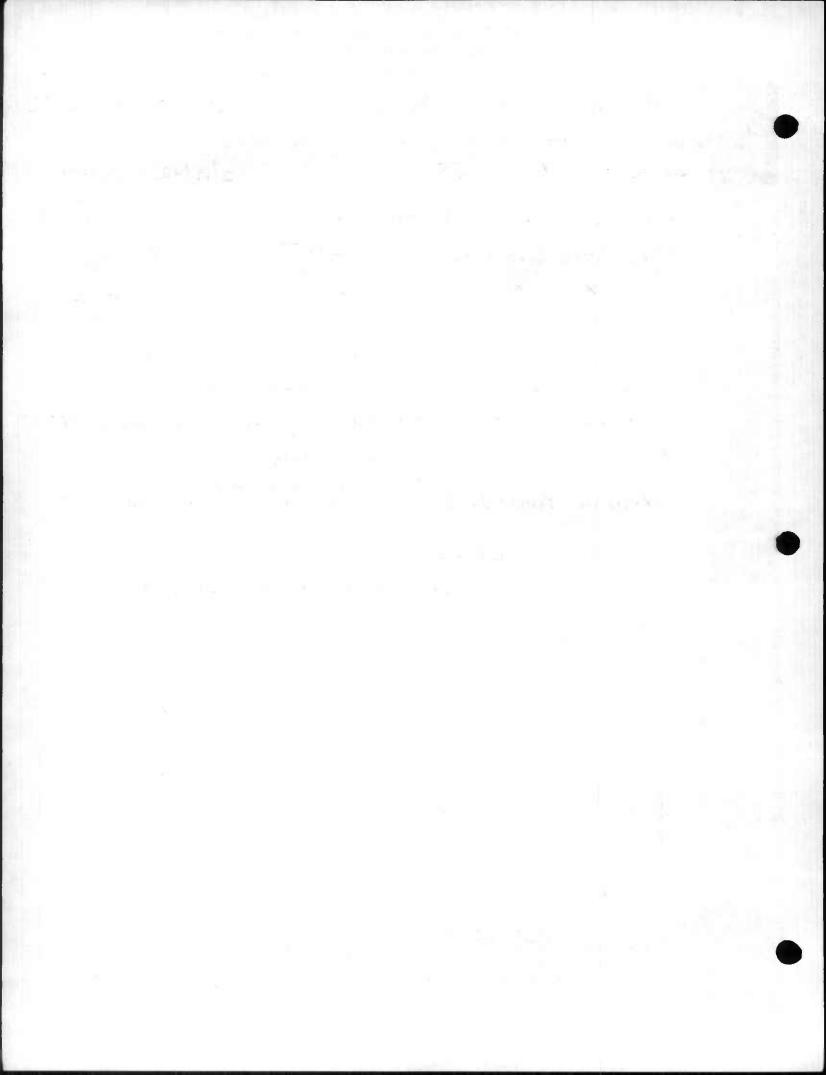
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	/Medi	cal	John Rathbone 4a. Facility Nama (If not institution	Tapley	-1			th City Town and		ARY 12	,199	
	Examir	ner	GREATER BAL		,	CENT	פשיו	4b. City, Town, or t	ocation of Dea		y of Death	
-	Funeral		5. Social Sacurity Number		Aga (In yrs. I		If Undar 1 Yaar		8. Data of B		LTIM 9. Birth	ORE placa (Stata or Foreign intry)
	Director		046-12-2452	to M 2□F		79 Yrs.	Months Days	Hours Min.		ay, Year) er 9, 19		Canada
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	r 28a	Director	Maryland Balti 10e. Street and Number	more		Cockey	sville 10f. Zip Code			10g. Citizen of	What Cou	untry?
	be filed within 72 hours after death with the Maryland nai Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	al D	13801 York Roa	ad			210	030		US	SA	
	ems .	Funeral	11. Marital Status	12. Was Decedar Armed Forcas	t Evar in U,S	S. 13. V		Hispanic Origin? (Spoan, Maxican, Puart	pecify Yas or N			ican Indian,
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9	0 0		1 ☐ Burial 2 🛣 Cramation 4 ☐ Donation 5 ☐ Other (S)		a				16.00			
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	/Medical Examiner		Immediata Causa (Finel disaasa or condition rasulting in death)	. Ma	SSIV	re c	icut	5 1017				6-15hr
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0	ding I h. After funer	tion	1 Natural 5 ☐ Pending		ey Year)	28b. Tima of Injury	28c. Inju Wo M 1	ryat vrk?]Yas 2 ☐ No	28d. Describe	how injury occu	rred	
DIVISION	Attan r deal pctor: by the	ifica	3 ☐ Suicida 6 ☐ Could r	not be 28a. Placa of Ir			at, factory, office		28f. Location	(Street and Num	ber or Rur	ral Routa Number,
5	s afte	Certification:	4 Homicida	building, a	atc. (Specify))			City or To	wn, Stata)		
	To the Hospital or Attanding Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifiar 1 Certifying (Check only 2 Medical F	g Phyeician: To the besis	t of my know	rladga, death	occurred et the ti	me, date end place	and dua to the	cause(s) and m	annar as :	stated.
	the H hin 24 the F nplete	Medi	one)	and mannar s	statad.	OFF AFFICE OF THE			190 at tha thha			
	5 4 € 0 0 0 4 € 0		29b. Signature and title of certifier	1/Quto	1	10	29c. Lican	sa number	1/_	29d. Daja signe	od (Month,	, Day, Year)
	.0		20 Name and side	1100000	4-10 0	0017		(XOV)	1	VIII	17	0
	10		30. Nama and eddrass of person v	wno completed cause of	oeeth (Itam	∠3e) (Type, F	rint)					
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	Registr	ar	1 20 4 (1330	n media	rhandal	•					



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			C	ertificate of Death	Reg. No.	06627
	Dhysisi		Decedent's Neme (First, Middle, Last)	2.1	Dete of Deeth Month Dey Yes	3. Time of Deeth
	Physici /Medi		MARTIN Richard W	ADDELL	Dete of Deeth Month Dey 12 9	8 16:32
	Examir		4e. Fecility Neme (If not institution, give street end number)	4b. City, Town, or Location	on of Deeth 4c. County of De	eeth
		Ш	UNIVERSITY OF MARYLAND MEDICAL SI		E	
	Funeral Director		5. Sociel Security Number 2.18 - 40 - 1.514 Usuel Residence of Decedent 6. Sex 170 M 2 F 7. Age (In yrs. lest birthdi		Dete of Birth (Month), Dey, Year) 2 19 42 Ma	Sirthplece (Stete or Foreign Country) LRYLANO
	dand dand		10a. Stete 10b. County 10c. City, Town or	Location		10d. inside City Limits
	Many a-f sh	tor	MD CARROLL WEST	MINSTER		1 ☐ Yes 24 No
	th with the 23a or 28	Funeral Director	10e. Street end Number 2325 COON CLUB ROAD	10f. Zip Code 2 1.57	10g. Citizen of Whet	
5-0020	swithin 72 hours efter death with the Maryland ilene. Then "natural", or items 23a or 28a-f show the Modical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No 1961 - If Yes, Give Year or Detes: 1963	 Wes Decedent of Hispenic Origin? (Specify If Yes, specify Cuben, Mexican, Puerto Rice Yes 2 No Specify: 	Yes or No- en, etc.) 14. Rece - A Black, W Specify:	merican indian, hite, etc.
5-0	72 h	Completed	(Specify only highest grede completed) (G.	ecedent's Usuel Occupetion live kind of work done during most of working	16b. Kind of Busines	ss/Industry
2121	filed within Hygiene. ther then "I int, the Mas	mpl	Elementery/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)	, ,	*
	illed with Hygiene. other than		17. Fether's Name (First, Middle, Last)	nagement 18 Mother's Name (Fig.	Londont rst, Middle, Meiden Sumeme)	cowne
Maryland	2 4 5 5	To Be	Samuel Waddell		lippion	
ary	2 should by and Menta is marked surretic ex	F		ailing Address (Street end Number or Rural Ro		e. Zip Code)
77.7	d the			25 Coon Club Rd.,		
re,	es 1 and of Health litem 27 r other tr		20e. Method of Disposition 20b. Piace of Dis	sposition (Neme of 2/16/98 ^D		
altimore,	D = 0		A Depoting F Other (Specific)	naah Camatanu	linuand	MD
alti	Depertment Important: any injury		21. Signature of Funeral Service Licensee	22. Name end Address of Fecility	0 (1 1	
Ω	88 5 8		23a. Pert1. Enter the disease, or complications that caused the death. Do not shock, or heart feilure. List only one cause on each line.	Pritts Funeral flo	me a chapel	MD
			23a. Pert1. Enter the disease, or complications that caused the death. Do not shock or heart failure. List only one cause on each line.	enter the mode of dying, such es cerdiac or re-	spiretory errest,	Approximete intervel Between
Я	Physician		Site of the site o			Onset end Deeth
1	/Medical Examiner		immediate Ceuse (Final disease or condition resulting in death) e. HypoxiA			
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687	fifficete ng physi es the	Medical	resulting in deeth) Lest Due to (or es e cons	sequence of):		
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	death e ette d for	Icla	Pert II. Other significant conditions contributing to death but not resulting in the	a underlying cause given in Bert I	23b. Did tobecco use contribu	ute to the cause of deeth?
P.0	that the dended by the e	Physician/	To the state of th	a underlying couse given in Ferci.		Probably 4 Unknown
	es that igned I be det	by F				
of Vital Records,	aw requires to been s	Completed			24e. Wes en eutopsy performed?	b. Were eutopsy findings eveileble prior to completion of cause of deeth?
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/ita	ysician: This contificate	Be	25. Wes cese referred to medical exeminer?	26. Plece of Deeth (Cl	neck only one)	
of V	0 0	2	1 Yes 2 No Hospital: 1 □ inpatient 2 XER/Outpet		5 ☐ Residence 8 ☐ Other (S	pecify)
n	ding P. h. After ti funera	on:	27. Menner of Deeth 1. ■Naturei 5 □ Pending 28e. Date of injury 28b. Time injur injur	y Work?	Describe how injury occurred	
sio	Attending ir death. octor: After by the fune	cati	2 Accident investigation	M 1 Yes 2 No		
Division	N or Attend effect death Director: / d in by the	Certification:	4 Homicide 4 Homicide 4 Homicide 28e. Plece of Injury - At home, ferm, building, etc. (Specify)	street, factory, office 28f.	Location (Street end Number or City or Town, Stete)	Rurel Route Number,
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	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or end manner stated.	Investigation, in my opinion, death occurred e	t the time, date end place, end d	es steted. lue to the ceuse(s)
	ro the	Me	29b. Signeture end title of certifier	29c. License number	29d. Date signed (Mo	onth, Dey, Year)
	2 - 0		Muchael (, Kolnich M. 1).	741396	02/12/	98
		-	30. Name end eddress of person who completed cause of deeth (Item 23e) (Typ	pe, Print) 22 South Greene		
			MICHAEL A. ROINIC	oo, Print) 22 South Greene K UNIV. OF MAN	RYLAND HOS	PITAL
	Sta		31. Dete filed (Month, Dey, Yeer) 32. Refietrer's Signature	.11		
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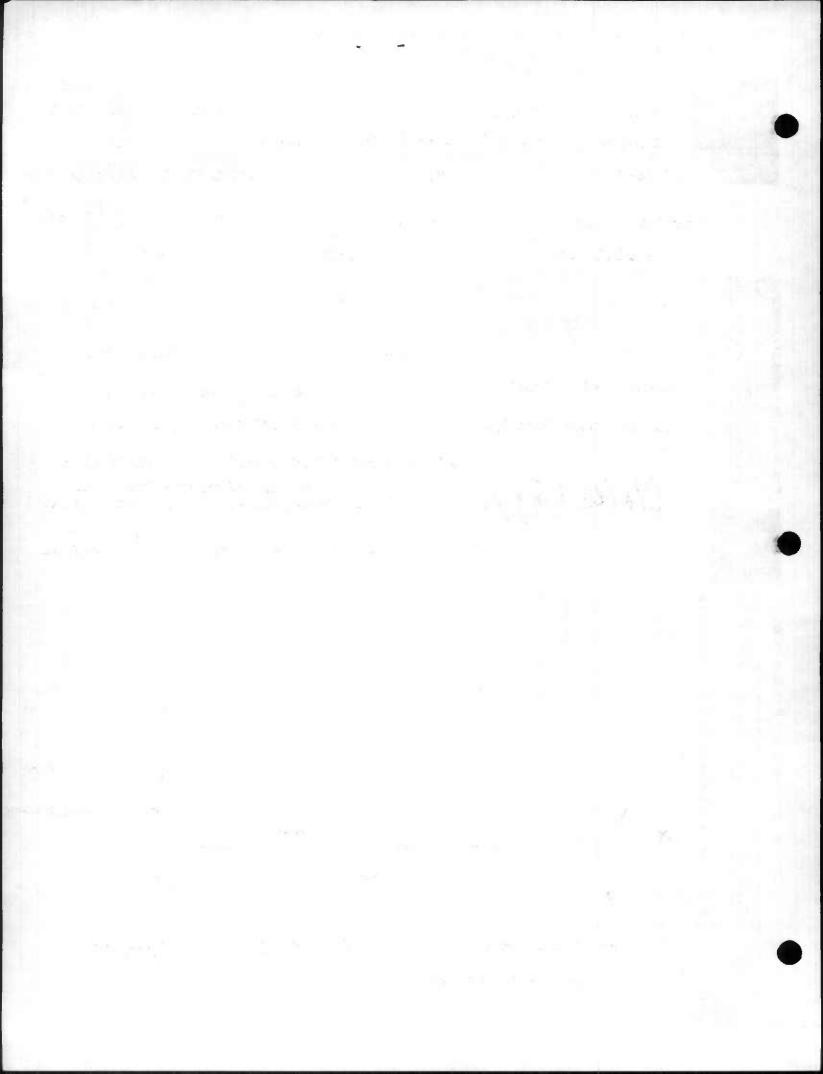
State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Data of Death **Physician** Month February 14, 1998 5:10 AM William Dwight Waddell /Medical 4e. Facility Neme (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Young At Heart - 1518 Philadelphia Rd. Joppa Harford 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days 1**⊠** M 2□ F Director 231-18-5790 March 17, 1905 North Carolina Usual Residence of Decedent death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal must be notified at 1 ☐ Yas 2 No Directo Maryland Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1817 Kalmia Road 21015 USA by Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, atc. filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Yaer or Dates: 21215-0020 Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Cattle Farming 10 Farmer Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be h and Mental h Pagas 1 and 2 should be Eugene (nmn) Waddell Mande Perkins (nmn)_ 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) t of Haelth a: If Item 27 is 1817 Calmia Road, Bel Air, Maryland 21015 other 1 William Vance Waddell/Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removal from State Department of Important: If any injury or 0 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Memorial Gardens 2-20-98 Bel Air, Maryland 22. Name and Addrass of Fecility Howard K. McComas III Funeral Home, P.A. 23e. Part1. Enter the disaase, or complication in a caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 50 W. Broadway Street, Bel Air, Maryland 21014 **Physician** CEREBRAL VASCULAR Accident /Medical Immediate Ceuse (Final disease or condition resulting in death) ~/WK Examiner Due to (or es e consequenca of): Examiner The lew requires that the death cartificate be axecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760, physician Physician/Medicai Due to (or es a consequence of) signed by the attanding Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? 24e. Wes en eutopsy performed? cartificata 1 ☐ Yes 2 ☐ No Division of Vital spital or Attending Physician: The hours after death.

neral Director: After this cardicate y filled in by the funeral director, pa 25. Wes case referred to medical 26. Plece of Deeth (Check only one) exeminer? 1 Yes 2 No Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) ASSISTED CAPL 2 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Manner of Deeth Certification: 28c. Injury et Work? 1 Yes 2 No 28d. Describe how injury occurred 28b. Time of Dete of Injury (Month, Day Year) 5 Pending 1 Naturel 2 ☐ Accident investigation MIA NA 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aff To the Funeral Di complataly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and mannar stated. Medical 29e. Certifier 29b. Signature end title of certifier 29d. Dete signed (Month, Dey, Year) do se no 3 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ALFRED SPANKS 31. Dete filed (Month, Payr earl 1998 Registrer's Signety Andall State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 1153_{Am} Month **Physician** BERTRAM BRADFORD WILEY 2 /Medicai 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Fallston General Hospital Fallston Harford If Under 1 Year Months Days If Under 24 Hrs. 8. Deta of Birth (Month, Dey, Yeer) 8/22/191 9. Birthplece (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) **Funeral** Months Hours Min M 2□ F 218-14-9022 84 Yrs. Director Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD. Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1317 Baldwin Mill Road 21084 Funerai mit. Pages 1 and 2 should be filed within 72 hours after death a barriment of Haelih end Mantal Hygiena. ortant: If Item 27 is marked other than "natural, or Items 23. injury or other traumatic event, in Medical Exactine mail. U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? Race - Amarican Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Naver Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 Specify: Caucasian 1 ☐ Yas 2 No þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Farming Farmer 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Bertram Bradford Wiley Sr. Mary Louisa Holland 19e. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Nancy A. Wiley Wife same as #10 20e. Method of Disposition
1 ☑Burial 2 ☐ Cremetion 3 ☐ Removal from State 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete Department of important: If any injury or once. Bethel Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 18/98 Madonna, Maryland 22. Name and Address of Facility
Kurtz Funeral Home, P.A. 21. Signature of Funerel Service Licensee 23a. Pert1. Enter the disaasa, or complications that causes the deeth. Do not enter tha mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each failure. Jarrettsville, Maryland Approximete Intervel Batween Onset end Death **Physician** Potumenia 2 days /Medical Immediate Causa (Final disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Attending Physician: The law requires that the death certificete be axecuted the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in deeth) Lest and Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequence of): signed by the et Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Obstructive Ph monny Vital Records, by Completed 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? 24e. Wes en eutopsy performed? hes After this certificata 1 Yas 1 ☐ Yes 2 ☐ No filled in by the funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) P 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 27. Menner of Death 28c. Injury at Work? Certification: 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Netural deeth. 1 ☐ Yes 2 ☐ No s aftar deeth. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 50 To the Hospital o within 24 hours af To the Funeral DI completely filled in 1 Certifying Phyelofen: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. Medical 29a. Certifier (Check only one)

29c. Licansa number

Bel Air Mary land

Nay Fh A 1911 to 32 Repair of Argusta

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

11/1

29d. Data signed (Month, Day, Year) February 15, 1998

State Registrar 29b. Signeture end title of certifier

31. Dete filed (Mor

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Item: 7, per F.H."G-757 3/4/98 reb Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) NICHOLAS 28, ACREE FEBRUARY 1998 3:35 AM 4a Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Deys Hours Min. F E B 9, 1920 Birthplace (State or Foreign Country)
 MD 15€M 2□ F 220-01-1034 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTO 1 X Yes 2 □ No MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21234 U.S.A. 2541 PERRING MANOR 12. Wes Decedent Ever in U,S. Armed Forces? 1\(\overline{\text{T}}\) Yes 2 □ No if Yes, Give Year or Detes: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Bieck, White, etc. 1 Never Memled 2 N Married 1 Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) 7 t h Collaga (1-4or 5+) TRUCK DRIVER TRUCK CO 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) ALONZO ACREE MARY PRICKER 19e. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 2541 PERRING MANOR BALTO, MD 21234 FLORA BELL ACREE 20e. Method of Disposition 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata MAR 5 \$□Suriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) GARRISON FOREST CEM 1998 OWINGS MILLS, MD FUNERAL HOME BETTS 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility 1129 N. CAROLINE ST BALTO, MD 21213 raa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrast, shock, or heart feilure. List only ona causa on aech lina. Approximete Interval Between Onset end Death END STAGE DILATED CONGESTIVE CARDIOMYOPATHY Immediate Cause (Finel disease or condition resulting in deeth) Due to (or es a consequence of): Due to (or es e consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yas 200 No 3 Probably 4 Unknown 24b. Wara autopsy findings evailable prior to 24e. Wes en autopsy completion of ceuse of daeth? 26. Place of Death (Chack only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician ziviedicai **Examiner**

Physician

/Medical

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10a. State

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7 is marked other than "natural", or items 23s or 28s-f sho treumstic event, the Medical Examinar must be notified at

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Depertment of Important: If It eny Injury or constant

Pages 1 end 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital or Attending Physicien:

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Examiner ettending physician and for use es the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaasa or Injury Physician/Medical that initiated events resulting in death) Lest 88 signed by the e

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Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

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25. Was cesa raferred to medical examiner? Hospitel: 1□ Yes 2No 27. Mannar of Death Neture 5 Pending 2 Accident

investigation 6 Could not be datarmined 3 ☐ Suicide 4 | Homicida

Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, afc. (Specify)

28c. Injury et Work? 1 Yes 2 No

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

MARYLAND

28d. Describe how injury occurred

(Check only one) 29b. Signeture end title of certifier

29e. Certifiar

Certifying Physician: To the best of my knowledge, daeth occurred et the time, dete end piece, and due to the ceusa(s) end menner as steted.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, data end piece, end due to the cause(s) and manner stated. 29d. Dete signed (Month, Dey, Year) 29c. License number

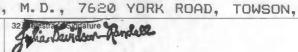
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JOGINDER P. MEHTA, M.D., State

31. Date filed (Month, Dey, Year)



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s of person who completed ceuse of death (Itam 23e) (Type, Print)

Registrar

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State of Maryland / Department of Health and Mental Hygiene

					Certifica	ate of	Death		Reg. No.	U	0031	
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Exami		4e. Fecility Neme (If not institution, gir	ve street end number)				4b. City, Town, or	Location of Dae		y of Death		
		THE JOHNS HOPK	INS HOSPITAL				BALTIMOR	RE CITY	Balt	imore	City	
Funera Director	_		Sex 7. Age (// 1 1 2 F 55	n yrs. lest birti	hday) If Und Month	ler 1 Year s Deys	If Under 24 Hrs	8. Dete of Bi	irth lay, Yaer) 14, 194	9. Birthi Cour 2 un	place (Stete or Fo htry) known	reign
and w.		10e. Stete 10b. County	10	Oc. City, Town	or Location						Od. Inside City Li	mits
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Maryland Z I Z I 3-0020 id 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It's marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examinar must be notified as	by Funeral	11. Marital Status 1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? UI 1 ☐ Yes 2 ☐ No If Yas, Give Year or Dates:	ľknown	13. Wes Dec If Yes, sp		Hispanic Origin? (Spen, Mexican, Puer Spacify:			Rece - American Indian, Bleck, White, etc. ecity: /Black		
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DSAILIMOTE, MEDIT PROPERTY PROPERTY IN THE STATE AND INJURY OF OTHER THRU PORCE.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☑ Other (Speci	Removel from Stete	20b. Plece of cemeter)	Disposition (N v, cremetory or	lame of r other ple	ece)	Deta	20c. Location	- City or To	own, Stete	
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of the office of	Me	29b. Signature and title of certifier	10 -0 11.		2	9c. Licen	se number	T	29d. Dete sign	ed (Month,	Dey, Yeer)	
P 5 P 0		> Muchael O	William	14. M	1)	040	19091		Februar	my 2	5,1998	-
V		30. Name and eddrass of person who Michael A William	completed cause of death	Wolfe	Type, Print) Street	- Me)09 (!xer 8-14	D Bal	Himore,	40	21287	,
St Regist	ate	31. Dete filed (Month, Day, Year) MAR 0 4 1998	32. Registrer's	Signature	484							

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month BROWN DWARD reb 4a. Facility Name (If not Institution, giva streat and numbar) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Nursing Center Ellicott City Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 1√2 M 2□ F Months 217-18-6811 75 Yrs. MAY 19, 1922 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Md. Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5874 Whisper Way 21075 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 XD Yes 2 □ No If Yes, Give Year or Detes: WWII 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 20 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collage (1-4or 5+) Electronics Technician 12 Westinghouse 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Wallace H. Brown Margaret Fry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Patricia Brown - wife 5874 Whisper Way, Elkridge, Md. 21075 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 3/4/98 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Pk. Elkridge, Md 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., Elkridge, Md. Pint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Immediate Cause (Final disease or condition rasulting in death) piratora Due to (or as a consequance of): 7 Due to (or as a consequenca of): crette Snoking Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 19 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

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Completed

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Director

flied within 72 hours after death with the Maryland Hygiene.

ther than "natural", or items 23a or 28s-f show

permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien. Important: if them 27 is marked other that may injury or other transment.

Baltimore, Maryland 21215-0020

P.O. Box 68760

Records,

Division of Vital

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated avants rasulting in death) Last

Aellitis, NID

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 26. Place of Death (Check only ona)

1 ☐ Yes 2 ☐ No

21043

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manper of Death

5 Pending Investigation 6 Could not be datarmined 28a. Date of Injury (Month, Day Yaar)

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28b. Time of

Othar: 4 Nursing Home 5 ☐ Rasidenca 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar

1 Natural

2 Accidant 3 ☐ Suicide

4 Homicida

29b. Signature and little of certified

D35309

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

SANDRA SATTIN mo

31. Data filed (Month, Day, Yaar)

MAR 04

32. Registrar's Signature relia Didoor Randoll

DHMH 16 Rev 6/95

State

Registrar

To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending prival completely filled in by the funeral director, page 2 should be detached for usa as when

by

Completed

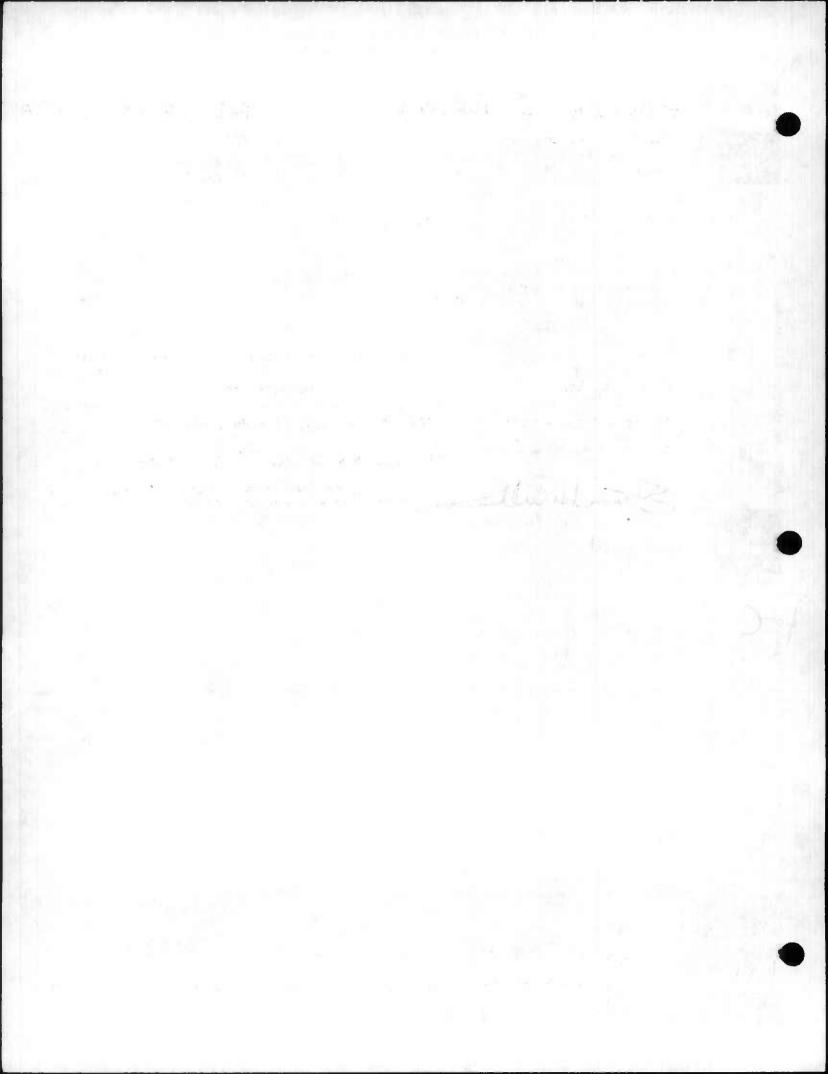
Medical Certification: To

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)

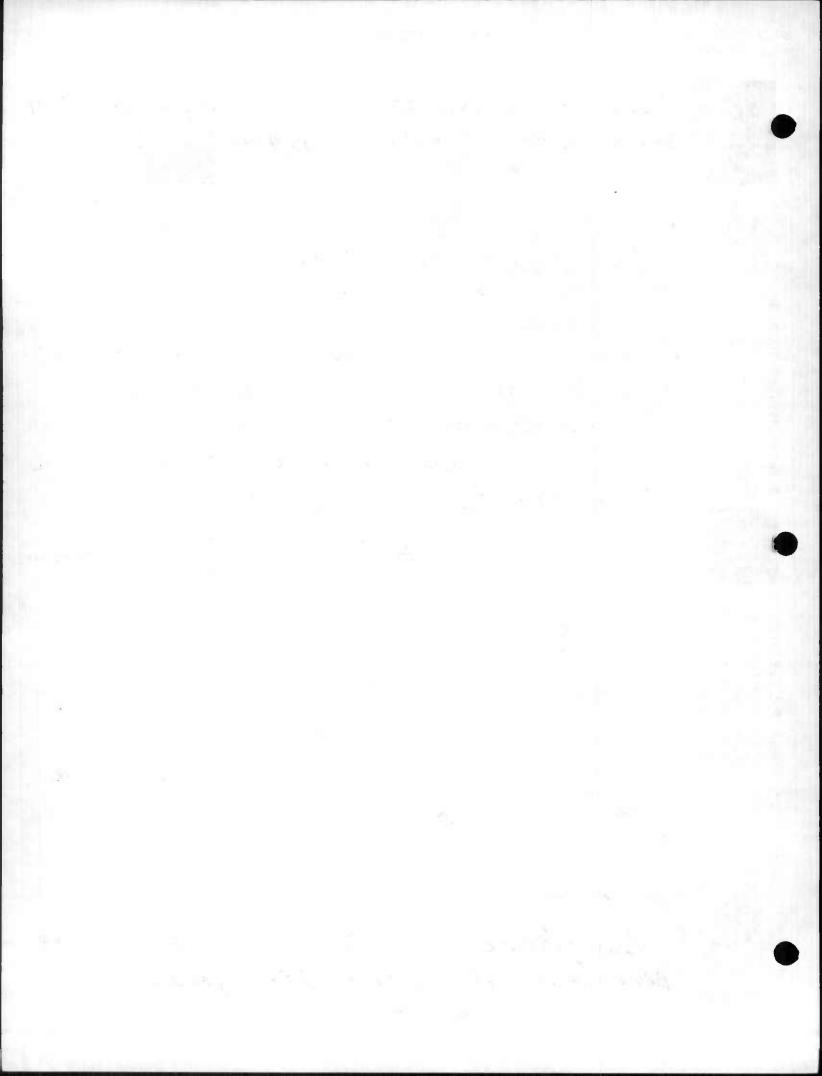
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29d. Date signed (Month, Day, Year)



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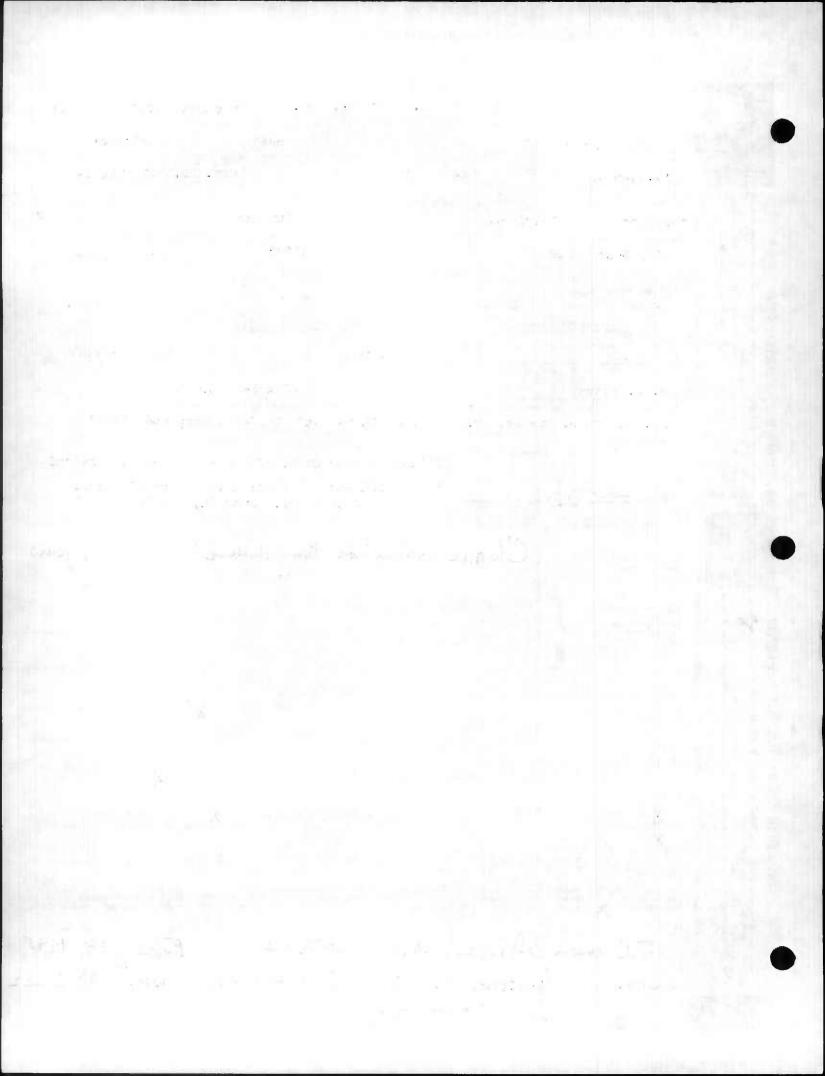
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Funeral Director		5. Social Security Number 6. Se 219 - 78-0053 10 Usual Residence of Decedent	7. Age (In yrs	Yrs. Iast birthday) If U	nder 1 Year If Under 24 Hr ths Deys Hours Min		Year) 70	9. Birthplace (State Country)	a or Forai
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of He r other		20a. Method of Disposition	20b.	Placa of Disposition camatary, cramatory	(Nama of			City or Town, State	XIOLI
nent of l		1 ABurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Tellioval Irolli State	M	. 0	3/6/98 5	20.10	IlsTown,	MI
Department of important: If any Injury or once.		21. Signature of Funeral Servica Licens		118 m	oeial Hack	210178 1	HOUH	ilis lown,	TIL
Departra Importa any inju		A Day	1 /	110	202 8/11	2	Aro.		
		man out the disease warmen	auch	7	500 1000	nan			
		23a. Part1. Enter the disease, or compleshock, or haart tailura. List only of	ne causa <i>on</i> aach lina.	in. Do not enter the	mode of dying, such as cardi	ac or respiratory arre	st,	Approxim Interval B Onset an	etween
hysician /Medical		Immediate Causa /Final		115) ()	o Dodin
xaminer		disease or condition	B	1+16	/)			unki	10001
	6		Due to (or as a consequenca	ot):				
nsit	듣		b						
and el-tra	xa	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequenca	ot):				
ng physicien and as the burlel-transit		Cause (Disease or Injury	C						
phys the		resulting in death) Last	Due to (d	or as a consequenca	of):			į	
and the cean centificate or executed of by the ettending physicien and deteched for use as the buriel-transit			d			_			
ettendir I for use	Slar							1	
igned by the ette be deteched for	ysic	Part II. Other algnificant conditions con	ntributing to death but not re-	sulting in tha underlyi	ng causa givan In Part I.	23b. Did tot	sacco uae co	ntribute to the caus	e of dea
d by						1 □ Ye	s 2□No	3 Probably 4	Unkn
5.8								I	41 - 41
been s should	eee					24a. Was an perform		24b. Ware autops evellable prio completion o	or to
ge 2 s	ng.							of death?	ii Qadao
	S					1 ☐ Ye	s 2 No	1 □ Yes 2	No
is certificate director, pag	d)	25. Wes case reterred to medical			26. Place of De	eath (Check only one)		
0.0		1 ☐ Yes No	Hospital: 1 ☐ Inpatient 2	ER/Outpetient 3□	DOA Other: 4 Nursing	Home 5 Resider	nca 6 🗆 Oth	er (Specity)	
h. After th funerel		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	28d. Describe hor	w injury occur	red	
	atic	2 Accident investigation	(33,33,43,43,43,43,43,43,43,43,43,43,43,4	M	1 ☐ Yes 2 ☐ No				
454		3 Suicide 6 Could not be datarmined	28e. Piace of Injury - At h	nome, farm, street, fac	ctory, office	28f. Location (Str. City or Town,		er or Rural Routa N	um <i>ber</i> ,
500	Se		building, atc. (opaci	•97		Only of Town,	Olala)		
455		29a Cartifier 100 Cartifying Phys	sician: To the best of my kno	owladge, death occur	rad at the time, date and place	e, and dua to tha ca	usa(s) and ma	innar as stated.	
455	le	(Check only o Title # 15	ner: Un the basis of examina	ation and/or investiga	tion, in my opinion, death occ	curred at the time, da	te and place,	and dua to tha cause	a(s)
45.5	edical ((Check only 2 Medical Examinations)	and marrier stated.						
45.5	Medical	Check only 2 Medical Exami	11111		29c. License number	29	d. Date signe	d (Month, Day, Year)	
24 hours effer Forneral Dir- stely filled in	edical	one) 2 Medical Exami	11111		29c. License number 32 532	29	E 6 mm	d (Month, Day, Year)	
45	Due to (or as a consequence ot): Due to (or as a consequence ot):		29	E 6 mm	d (Month, Day, Year) y 26, 19				
# 는 c	edical	29b. Signature and titla of cartifier 30. Name and eddress of person who co	11111	m 23a) (Type, Print)	29c. License number D 32532 and Eme	ere ones Ma	Ebrum	d (Month, Day, Year) y 26, 19	



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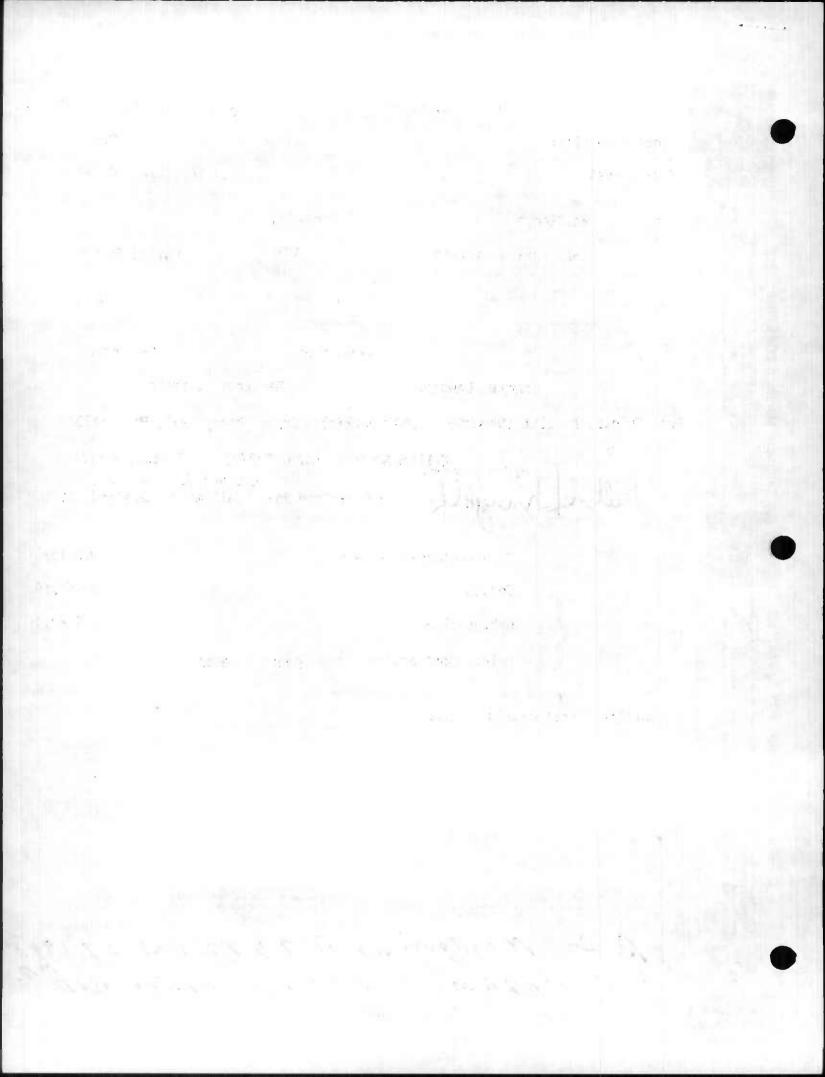
State of Maryland / Department of Health and Mental Hygiene Q 8

				Certificat	e of Death	R	eg. No.	UO	0 3 4				
ysician	Decedent's Name (First, Middle, L.		7.7	5		2. Dete of Dee Month	Dey	Yeer	Time of Deat				
Medical		Albe	rt W.	Braue		Februar	-		11:40				
aminer	4e Fecility Neme (If not Institution, g	ive street end number)				or Location of Deeth	4c. County						
	218 Ashwood I 5. Sociel Security Number 6.		e (In yrs. lest bi	etadou) If t Inde	Dunda 1 Year If Under 24 F			timore	(Chata or For				
ral tor	217-24-0202 Usuel Residence of Decedent	153M 2□ F	66	Yrs. Months		in. 8. Dete of Birth (Month, Dey NOV • 2	Yeer) 3,1931	9. Birthplece Country) Maryla					
by Funeral Director	10e. Stete 10b. County	altimore	10c. City, Tow	m or Location	Dund	lalk			nside City Lin				
il Director	10e. Street end Number 218 Ashwood Road			10f. Zip	Code 21222	1	Og. Citizen of V	Whet Country?	25				
by Funeral	11. Maritel Status 1 Never Married 2 Merried 3 Novidowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Detes:			dent of Hispenic Origin? city Cuban, Mexican, Pu 2 Tho Specify:	(Specify Yes or No- erto Ricen, etc.)	14. Rec	White					
Completed by	15. Decedent's (Specify only highest g	Education rede completed) College (1-4or 5	16a	Decedent's Usu (Give kind of wo life. DO NOT u	el Occupation ork done during most of u se retired)	working	16b. Kind of Bu	siness/Industr	y				
Com	9 Years			Welde				Indust	try				
Be	17. Fether's Name (First, Middle, Las	st)				leme (First, Middle,		ie)					
2	M. H. Brauer					abeth Scot							
	19e. Informent's Neme/Relationship				s (Street end Number or				e)				
	Mr. Albert W.	Brauer, Jr.			re Road Du			21222					
DUCE.	20e. Method of Disposition 1 □ Burial 2 □ Cremetion 3 4 □ Donation 5 □ Other (Spec		cemete	of Disposition (Nation), cremetory or copy.	ice Corp. 3	i	20c. Location -	n, Mary					
DUCE	21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Duda-Ruck Funeral Home of Dundalk, I 7922 Wise Ave. Dundalk, Maryland 2 23a. Perl1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,												
edical Examiner	Immediate Cause (Finel disease or condition resulting In deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	c	Due to (or es e	consequence of):	. 0	hseare		0	gean				
5		d											
/ Physician/	Pert II. Other aignificant conditions	contributing to death be	ut not resulting l	In the underlying	ceuse given In Pert I.	23b. Did to	obacco use co / /es 2 No	3 Probably					
Completed by						24e. Wes e perfor			le prior to tion of caus				
mo						1 🗆 Y	es 2 No	1 □ Ye	s 2 No				
To Be	25. Wes cese referred to medical exeminer? 1 Yes 2 □ No	Hospitel: 1 ☐ Inpatie	nt 2 ER/O	utpetient 3□ D	Other	Deeth (Check only of		er (Specify)					
	27. Manner of Death 1 Neturel 5 Pending 2 Accident investigati	28e. Dete of Injui (Month, De)	y 28b.	Time of Injury M	28c. Injury et Work? 1 □ Yes 2 □ No	28d. Describe h		red					
Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, fac. (Specify)	arm, street, factor	y, office	28f. Location (S City or Tow	treet end Numb n, State)	er or Rural Ro	ute Number				
edical			examinetion er		et the time, dete end plan, in my oplnion, deeth o								
Medical Certificati	29b. Signeture end title of certifier	Ofonova	" M	.) .	0. License number De 76 3 2		Pebua	d (Month, Dey, y 28,	Year) 199				
	30. Name and address of person wh	Completed ceuse of d	eeth (Item 23e)	(Type Print)			0	1					



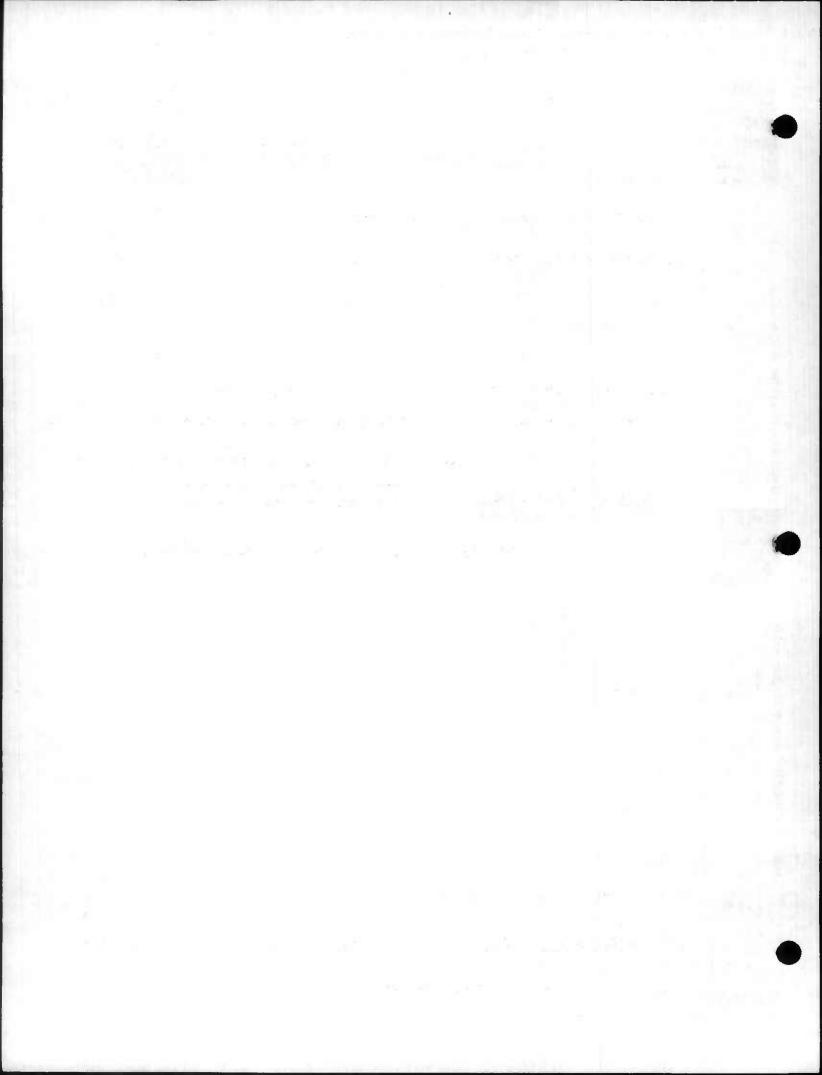
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2	thet initieted events resulting in death) Lest		r as e consequenca			D1 44		?	
20		Urinary Obs	cruction	Neur	rogenic	Bladder			
Physiclan/M	Pert II. Other eignificant conditione	contributing to death but not res	ulting in the underlyi	ng ceuse giver	n in Pert I.	23b. Did 1	obecco use con	tribute to	the couse of death
by -	Multiple area	s ofskin breakd	lown			10	Y●● 2 No	3 Probe	ably 4 Unknow
Completed						24e. Wes perfo	en autopsy med?	evei	e eutopsy findings leble prior to spletion of cause eeth?
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e 25	25. Wes case referred to medical examiner?	Hospitel:		Other	r	eth (Check only o			
P 27	1 X Yes 2 No 27. Manner of Deeth	28e. Dete of Injury (Month, Day Year)	28b. Time of	28c. injury	4 Nursing H	lome 5 Resid	ience 6 LOthe		
Certification:	1 Neturel 5 Pending investigat 3 Sulcide 4 Homicide 6 Could not determine	ion	Injury M ome, ferm, street, fac	1 U Y	r res 2□No	28f. Location (S City or Tov	Street and Numbern, State)	er or Rural	Route Number,
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30	_	a considered assume of death (the	23e) (Type, Print)	2 -	1110.1	Hor	PITAL	.13	1.199



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						Certificate				Reg. No.	8 (16636
	Physic /Medi		1. Decedent's Neme (First, Middle, Las Robert Emmet	· ·	Jr.				2. Dete of De March	2, Day 998	Year	3. Time of Deeth 3:00 A.M.
ز	Exami		4a. Fecility Name (If not institution, give	street end number)			4b. Cit	ty, Town, or Lo	ocation of Deet	h 4c. County	of Deeth	
			Genesis Elder C					everna	_		Aru:	
	Funeral Director		5. Social Security Number 6. S 153-16-2524 Usual Residence of Decedent	ex 7. Age	9 (In yrs. lest birt 75	Months D		Inder 24 Hrs. ours Min.	8. Date of Bir (Month, De March	th by, Year) 2, 1923	9. Birthp Coun New	lece (State or Foreign http) Jersey
	yland		10e. State 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
	Mar me-fat	ctor	Maryland Anne A	Arundle	Gle	en Burnie						1 ☐ Yes 2 ☒ No
	or 28	Director	10e. Street and Number			10f. Zip Co	de			10g. Citizen of	What Coun	itry?
	ath w		400 Woodlake Cour			21061				United	1 Sta	tes
020	is within 72 hours after death with the Maryland ilene. Than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at	by Funeral	11. Marital Stetus 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	TATTAT T.T.	13. Was Decedent If Yes, specify 1 Yes 2	Cuban, Me	exicen, Puerto	ecify Yes or No Rican, etc.)	Blac	e - Americ ck, White, Whi	etc.
21215-0020	filed within 72 hi Hygiene. other than enature.	Completed	15. Decedent's Ed (Specify only highest gre- Elementery/Secondary (0-12)	de completed) College (1-4or 5	+)	Decedent's Usual O (Give kind of work a life. DO NOT use n	one during	most of work	ing	16b. Kind of Bi		lustry
d 2	한 후 후 후		17. Father's Name (First, Middle, Last)	4		Engineer	18. N	Mother's Name	e (First, Middle	Defe , Meiden Sumen		
Maryland		To Be	Robert Emmett By	rne, Sr.				Mary C				
ary	d 2 should th and Mer 7 is marke treumatic		19a. Informant's Name/Relationship (7		19b.	Mailing Address (S				er, City or Town,	Stete, Zip	Code)
	D = 12		Mary Anne Byrne/ W	life	40	00 Woodla	ce Co	urt Ap	t. D Gl	en Burni	ie, M	D 21061
Baltimore,	permit. Pages 1 and Department of Healingortant: If Item 2 any Injury or other other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemeter	Disposition (Neme of cremetory or other ville MD.	r plece)		r. 6,	20c. Location -		
alti	mit.	l	21. Signature of Funeral Service Licen		CLOWIIS	22. Name and A	ddress of F	ecility			/1110	, 115
0	89188		1 huy Cb	augh)		Kirkley-					MD 2	1061
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lin	the death. Do n	ot enter the mode of	dying, suc	sh as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
4	/Medical Examiner	П	Immediate Cause (Finel disease or condition	MET	ASTA	TIC L	UNC	6 C	ARCIN	AMOU	3	L HTMOM &
		ner	resulting In deeth)	ı	Due to (or as a c	onsequence of):						
o,	be executed pician and buriat-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or es a c	onsequence of):						
x 68760,	ficate physical at the	Medical	resulting in death) Last	c	Due to (or as a co	onsequence of):						
Box	the str	clan										
P.O.	hat the d ed by the detached	Physician/N	Part II. Other significant conditions co	ntributing to deeth bu	t not resulting In	the underlying caus	e given In I	Part I.		Yas 2 No		the cause of death?
Records,	aw requires to been sign 2 should be	Completed by								an autopsy armed?	ave co/	ore autopsy findings allable prior to impletion of ceuse deeth?
E .	8 - 5	Соп							10	Yes 2 No	10	Yes 2□ No
Vital		Be	25. Was case referred to medical examiner?	Harris No.				Place of Deatl	(Check only o	one)	-	
5	Physician: This certific ral director,	10	1 ☐ Yes 2KMNo			patient 3 DOA		^		dence 6 □Oth		0
0	D 0 0	sation:	27. Manner of Death 1. DNatural 5 Pending 2 Accident Investigation	28a. Date of Injun (Month, Dey		ime of 28c. jury M	Injury at Work? 1 ☐ Yes		28d. Describe	how injury occur	red	
D P	2 2 2 2	Certification:	3 Suicide 6 Could not be 4 Homloide determined	28e. Place of Inju building, etc.	ry - At home, far (Specify)	m, street, factory, of	lice		28f. Location (: City or To	Street end Numb vn, State)	er or Rure	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	velcian: To the best of inar: On the basis of and menner stat	examination end	death occurred et the for investigation, in a	e time, dat ny opinion	te and place, , death occurr	and due to the ed at the time,	cause(s) and ma dete end piece,	inner as st end due to	ated. the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier	1A 4 .0			ense num			29d. Date signe		
	,		> Silled	~ MD		D	217	176		March 3	, 199	8
1	5		30. Name and eddress of person who c	ompleted cause of de	eth (Item 23e) (1	Type, Print)						
	- C4-	10	Dr. Surya Mundra 31. Date filed (Month, Day, Year)	32. Registra	E. Pata	psco Ave.	Bal	timore	, MD 21	230		
	Sta Registr		MAD n 4 1000		dson-Rang	lace.						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Deeth Dey 998 Month March 2, Lewis A. Becker 6:30am 4a. Facility Nama (If not institution, giva street end number, 4b. City. Town, or Location of Deeth 4c. County of Deeth Cherrywood Nursing Home Reisterstown Baltimore Co 5. Social Security Number if Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 1∑M 2□ F 139-07-9283 Yrs. Feb 4, 1907 London. Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 3 ☐ No Baltimore Co. Reisterstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 107 Brookebury 21136 USA 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 M No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, atc.) 14. Rece - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Jeweler retail 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Samual Becker Leah Morzansky 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Robert Becker/ son 107 Brookebury Dr., Reisterstown, MD 21136 20e. Method of Disposition 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2XX remetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation Services 2/3/98 Hampstead, MD 22. Name and Addrass of Facility 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136 23a. Part1. End to disured, or complications that caused the death. Do not enter tha mode of dying, such es cardiac or respiretory arrast, shock, or man ballure. List only one cause on each line. Approximata intervel Between Onset end Deeth Immediete Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? OPD 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy performed? 2 NO

Physician /Medical Examiner

Examiner

Physician/Medicai

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Completed

Be

Certification: To

Medical

25. Was cese referred to medical examiner?

1 ☐ Yes 20 No

Mannar of Deeth

Neturei

Physician

/Medical

Examiner

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Completed

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Show

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234 death

items :

filed within 72 hours aftar of Hygiene. ther than "natural", or iter

marksd other

Depertment of Heaith ar Important: If Item 27 Is any Injury or other trau

Pages 1 and 2 should be f nent of Heaith and Mental I nt: If Item 27 Is marked of

Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

with the Maryland

the attending for usa as signed by t pege 2 s director,

Records, P.O. Box 6876

Division of Vital

or Attending Physician: funeral After death. after death Director: / d in by the within 24 hours aft To the Funeral DI completaly filled in Hospital To the within 2

20 State Registrar

5 Pending Investigation 1 Yes 2 Accident 6 Could not be determined 3 Sulcida 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 11 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the basis of examination end/or Investigation, in my opinion, death occurred at the time, dete end plece, end due to the ceuse(s) end manner stated. 29a. Certifier 29b. Signature and title of certifier

28c. Injury et Work?

28e. Date of injury (Month, Day Year)

29d. Data signed (Month, Day; Year)

Other: Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Piace of Death (Check only one)

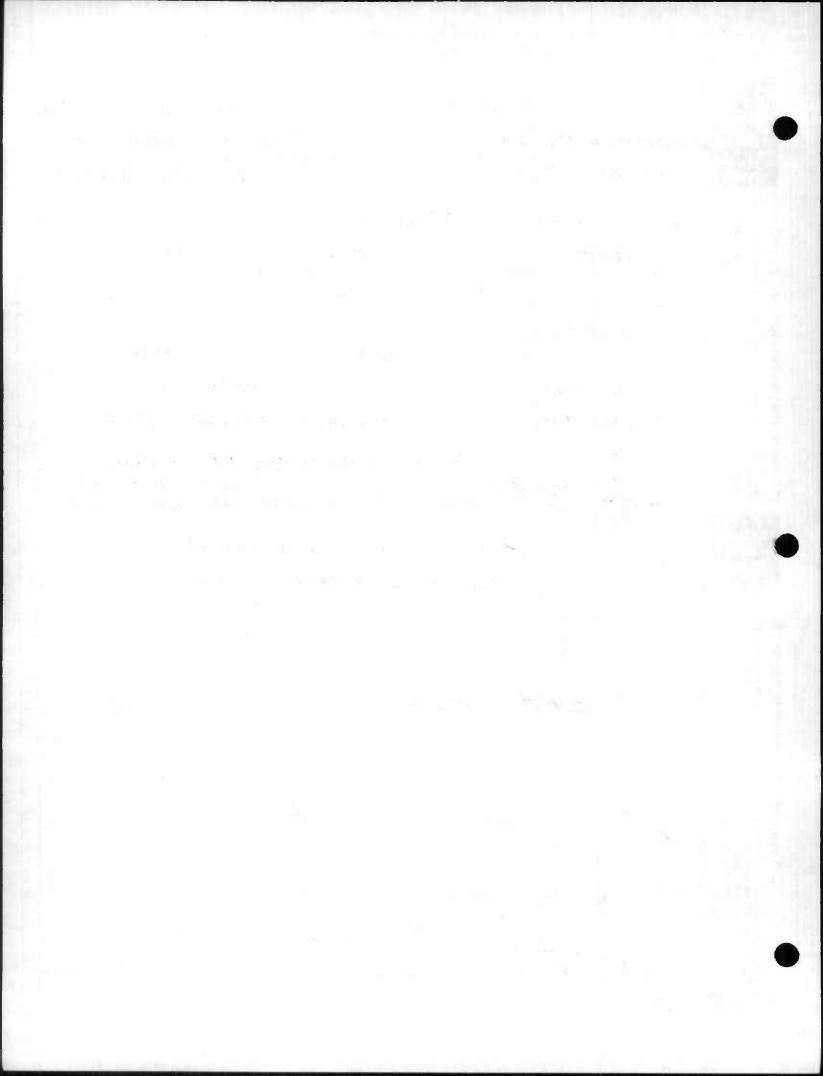
1 ☐ Yes 2 ☐ No

ause of degth (light 23a) (Type, Print) comes con Con Con Dr. Reisleed

32. Registrar's Signature Min Davidson

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Time of



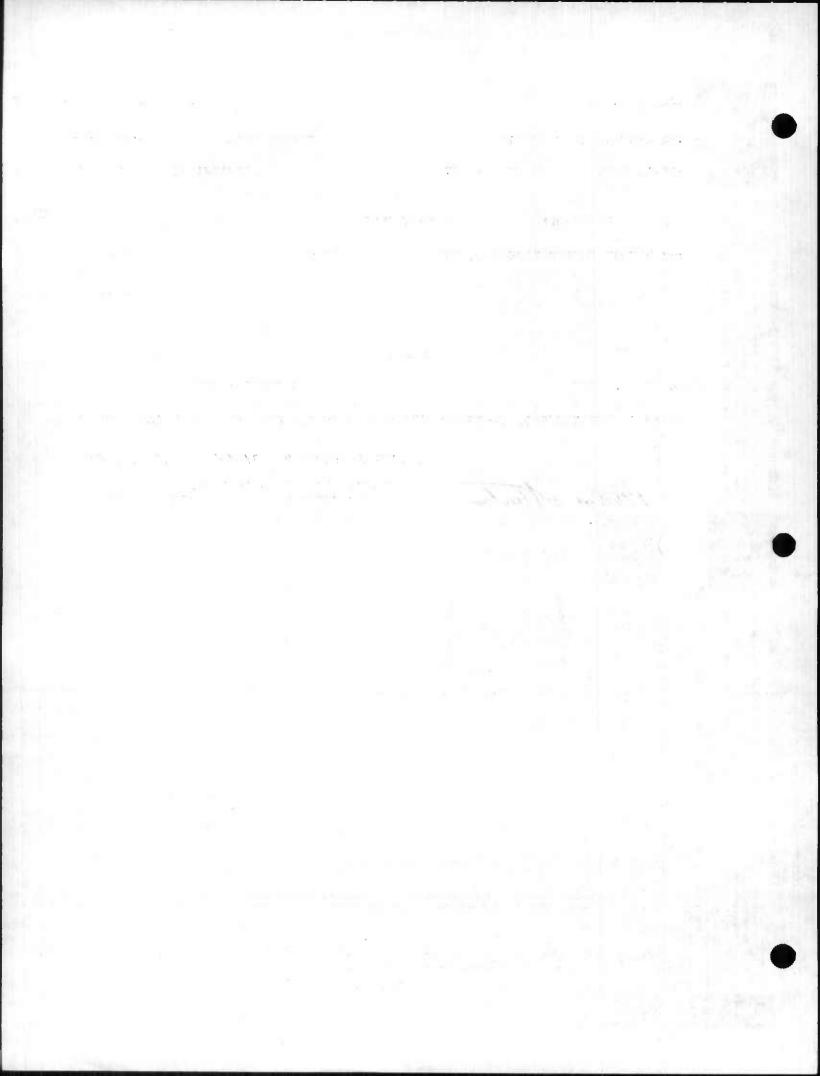
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decadant's Nama (First, Middle, Last) 3. Time of Death 2. Data of Daath Month **Physician** 2:551 MARY J. BRAY MARCH 01, 1998 /Medical 4b. City, Town, or Location of Daath 4a. Fecility Name (If not institution, give street end number) 4c. County of Death **Examiner** CHARLESTOWN CARE CENTER CATONSVILLE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth Months | Days | Hours | Min. | 01/12/1911 Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 7. Aga (In yrs. lest birthdey) **Funeral** 1□ M 2 F 216-12-3430 87 Yrs. Director Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show notified at 1 ☐ Yas ⊉ONo Director BALTIMORE CATONSVILLE 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda ir than "natural", or Itams 23a or 707 MAIDEN CHOICE LANE APT. 9210 21228 U.S.A. Pages 1 and 2 should be filed within 72 hours after death variet of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or Items 23.
ury or other traumatic event, it a feefing from the mail Funerai 12. Was Dacedent Ever In U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indian Black, Whita, atc. 1K Navar Married 2 Married 1 ☐ Yas 2 NO Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: WHITE by 3 Widowad 4 Divorced Completed 15. Decedant's Education (Specify only highest grede completed) 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) CLERK B.G.E. 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surneme) THOMAS F. BRAY BRIDGET KNIGHT 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21228 LOUIS E. LEILICH/BROTHER-IN-LAW 707 MAIDEN CHOICE LANE APT. 9210 CATONSVILLE, MD 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 20a. Mathod of Disposition important: If It any Injury or o 1 ☑Burial 2 ☐Cramation 3 ☐Ramoval from Stata permit. Page Department 4 Donation 5 Othar (Specify) NEW CATHEDRAL CEMETERY 3/4/98 BALTIMORE, MD 22. Nama and Addrass of Facility
STERLING ASHTON FUNERAL HOME, INC. 21. Signature of Funaral Service Licansee 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23a. Part1. Enter the disassa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Intarvel Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical . Chronic abstructive pulmonary discose **Examiner** Dua to (or as a consequance of): Physician/Medical Examiner ettending physician and for use es the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury Due to (or as a consequence ot): that initiated avants resulting in death) Last Due to (or es e consequence of): 80 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 3 Probably 4 ☐ Unknown 1 Yes 2 No ate hes been signed page 2 should be det þ 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performad? Completed 1 Yas 2 No 22 No of Vital 25. Was casa rafarred to medical axaminar? Be 26. Place of Daath (Check only ona) Hospital: Othar: 20 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas this funeral 28a. Data of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? Division 1 ☑ Natural 2 ☐ Accidant Attending 5 Panding 1 ☐ Yas 2 ☐ No invastigation death Director: 6 ☐ Could not be datamined 28a. Placa of Injury - At home, farm, straat, factory, offica building, atc. (Specify) 3 Sulcida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) filled in by 4 Homicida ò 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifian Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifiar 29c. License number 30. Name and address of person who complated cause ot daath (Itam 23a) (Type, Print) Catorsville Maiden C TU hoice 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura State MAR 04 1998 cha Savidson-Randell Registrar

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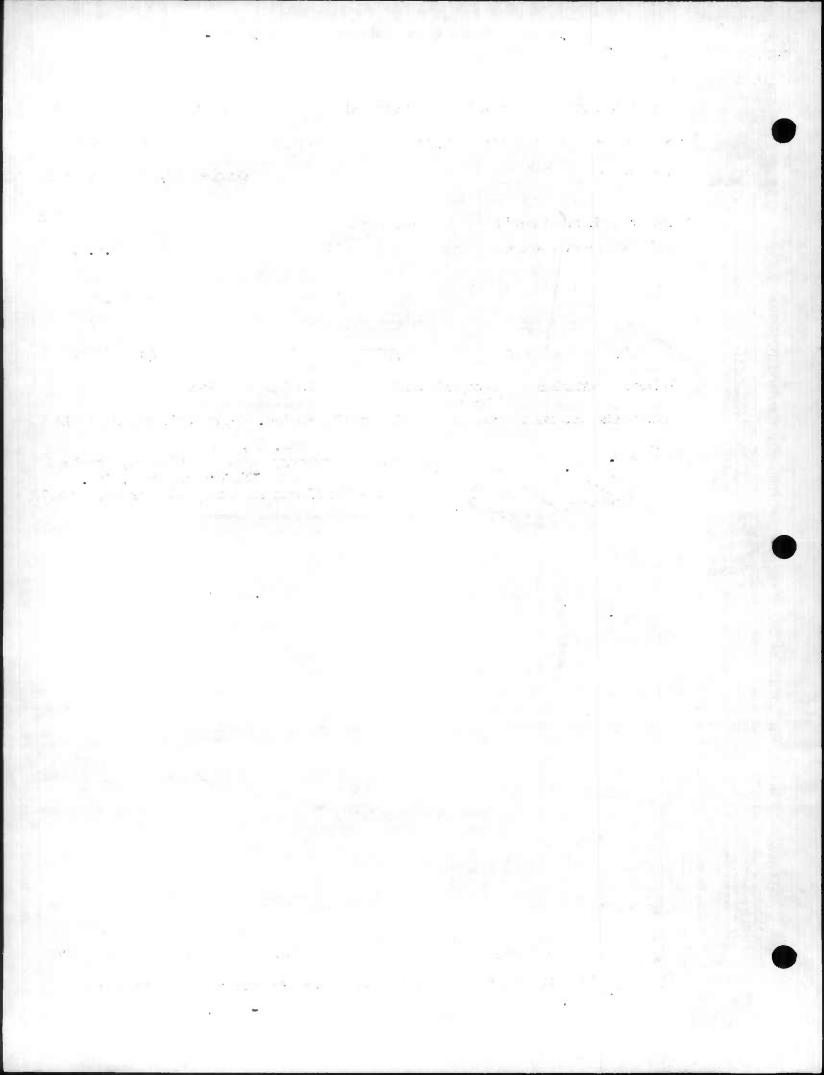
Name.



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CHRISTOPHER	J.	BACZYNSKI
CHILLYCACTITUTE		

	1. Decedent's Name	EO G-757 3, First, Middle, La			Certifica	ale oi	Deam	2. Date of De	Reg. No.	3.	Time of Death									
cian dica l	Chris	topher	Josep	h	Baczyns		4b. City, Town, or		Day	Year 1998 1	507PM									
niner			e street and number)		n			Location of Deat			TO STORY									
al or	5. Social Security No. 214-51-12	umber 6. S	HOSPITAL ex M 2 F	e (In yrs. las		dar 1 Yaar	CLINTON If Under 24 Hrs Hours Min.	. (Month, Di	th ay, Year)		(State or Foreign									
"	Usual Rasidence of	Decedent			4	10		octobe	r 17,199		nington									
-	10a. State	10b. County			own or Location						nsida City Limits									
Director	Maryland			U	pper Mar	lborc Zip Code)		10g. Citizen of											
Funerai Dir	10e Street and Num 9112 Gra	andhaven	Avenue			207	72			U.S.										
	11. Marital Status		12. Was Decedent Armed Forcas?	Ever in U,S.	13. Was De	cedent of h	ilspanic Origin? (S an, Mexican, Puer	Specify Yes or No)- 14. Rac	ce - Amarican Ir	ndian,									
	1 Never Marrie 3 ☐ Widowed		1 ☐ Yes 2 💢 I If Yes, Give Year or Dates:	No		2 X No	Spacify:			w White										
	(Space	15. Decedent's Ed	ducation de completed)	1	16a. Decedent's U (Give kind of life. DO NO	sual Occup work dona	eation during most of wa	orking	16b. Kind of B	usinass/Industr	у									
	Elamentary/Secon N/A	ndary (0-12)	Coltage (1-4or 5	i+)	N/A	Tusa retire	d)		N1 /2											
	17. Father'a Name (First, Middle, Last)			N/A		18. Mother's Na	ma (First, Middla	N/A , Maidan Suman											
	Robert	Charle	s Baca	zynski	, II		Leslie	Hud	ckno											
2	19a. Informant's Na	me/Relationship (Type, Print) (Fath	ner)	19b. Mailing Addr															
			aczynski,				ven Ave.													
	20a. Method of Disp Burial 2		Ramoval from Stata		e of Disposition (I				20c. Location	- City or Town,	State									
	4 ☐ Donation 21. Signature of Earl	5 □ Other (Specify		Re	surrecti			1998		n, Mary										
	21. Signature of part	rogs-surgan Ugar	1//W	1			ss of Facility Alexandr	Lee Fund	ral Hom	e, Inc.	MD 20735									
_	23a Part 1 Enter th	ne diseasa or form	olications (bat caused one cause on each li	the death						Apr	proximate erval Between									
Calcal Evaluated	Immediata Causa (I disease or condition resulting in daath)		а		T DEATH SYL															
	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disaase or	nditions, madiate rlying	D	Due to (or a	s a consequence	of):] 										
	that initiated events resulting in death) L		d.	Dua to (or as	s a consequance o	of):														
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	Part II. Other signifi	cant conditions o	ontributing to death b	ut not rasultii	ng in the underlyin	g cause giv	en in Part I.		Yes 2 No	3 Probabl	y A Linknow									
									s an autopsy ormed?	availat	autopsy findings ole prior to otion of causa h?									
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10 De	examiner? 1⊠ Yes 2□ I 27. Manner of Death 1 XXIII atural	No 5 Pending investigation	28a. Date of Inju (Month, Da) 28e. Place of Inju	y Year)	Injury M	1			2 Accident 3 Suicide 4 Homicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Street and Number											
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edical certifications, 10 De	examiner? 1\(\text{2}\) Yes 2 \(\) 27. Manner of Death 1\(\text{2}\) Matural 2 \(\) Accident 3 \(\) Suicide 4 \(\) Homicida 29a. Cartifiar (Check only)	No 5 Pending investigation 6 Could not be determined 1 Certifying Ph	28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc	ury - At home c. (Specify) of my knowle axamination	Injury M e, farm, street, fac odga, daath occurr n and/or investigat	tory, office	Ma, data and place	City or To	cause(s) and m	annar as stated, and dua to the	d. cause(s)									
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State of Maryland / Department of Health and Mental Hygiene

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	Physic /Medi		1. Decedant's Nama (First, Middla, La	B. I on	lan				2. Deta of Dea Month	th Day	Yaar 3.	Time of Deeth	
	Exami		4e. Fecility Nema (If not institution, give	re straet end number)	Co	mmunity	4	b. City, Town, or	Location of Death	4c. County	of Death		
			Fairhaven Contin		Retir	ement	India 4 Mars	Sykesvi	11e	Carro			
	Funeral Director				e (In yrs. las		Inder 1 Yaar nihs Deys	Hours Min		Year) 1908	9. Birthplaca Country) 0h10	Stata or Foraign	
	a-f show	ctor	10a. State 10b. County Maryland Carrol	1	10c. City, Syk	Town or Location esville	n					side City Limits ☐ Yas 2万No	
	23a or 28	ral Director	10e. Streel end Number 7200 3rd Aver.u€			10	of, Zip Code 21784		1	0g. Citizen of V	What Country?		
020	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	11. Meritei Stetus 1 □ Naver Marriad 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Wes Decedant Armed Forcas? 1 ☐ Yes 2 ☑ If Yas, Giva Yaar or Deles:			Decedent of H , apecify Cubs		Specify Yas or No- to Rican, atc.)	Biad	e-Amarican Inck, Whita, aic. White	neik,	
Maryland 21215-0020	vithin 72 hone. han "nature we Madical	Completed	15. Decedant's E (Specify only highest gra Elementery/Secondary (0-12)	ada complatad) Collega (1-4or 5			of work dona o OT usa ratired	during most of wo	orking		nd of Business/Industry		
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Baltimore,	Peges 1 emant of He ant: If Item ury or other		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Crametion 3 ☐ 4 ☑ Conation 5 ☐ Other (Special	Ramoval from State	20b. Pla	ce of Disposition natary, crematory	(Nama of		Data		City or Town, S		
Balt	permit. Departi Importi any inj		21. Signature of Funeral Service Lice Joseph B. Va	n Santa				ss of Fecility Comy Boar Marylar	rd, 655 W	. Balti	imore St	reet	
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	To the within? To the comple	≥	29b. Signature and title of certifier	and mannar sta	itad.		29c. License	e number	2	9d. Date slone	d (Month, Day,	Year)	
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Department of Health and Mental Hygiens. Important: If item 27 is marked other than *natural; or items 23a or it any injury or other traumatic event, the Medical Examiner must be a price. Pages 1 and 2 should be filed within 72 hours after death

Physician /Medical

Baltimore, Maryland 21215-0020

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		3.5		Certifica	ite of	Death		2. Date of Deeth Month FEBRUAR	Dey	Year	Time of Death	
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						D3 T III T	MODE				i +	
		7 Age (In ure	last hirth	day) If Und	er 1 Year	BALTI If Under	MORE r 24 Hrs.			more C		
unknown	1 M 2□ F	22	Yn	Months		Hours	Min.	8. Date of Birth (Month, Day, April 2	(ear) 0, 197	Country) 5 unkno	(State or Fore	
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21. Signature of Funeral Service Joseph		1				-		rd, 655 t	W. bal	timore	Street	
Part Enter the disease, of shock, or heert failure. Lis	r complications that t only one cause on	caused the dea each line.	ath. Do no						st,	Inte	proximate ervel Between set and Death	
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25. Was case referred to medic examiner?	st.					26. Plac	e of Deat	h (Check only one)			

Be Completed by Physician/Medical Examiner attending physician and for use as the burial-transit To the Mospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the a ld be detached t been sk should b within 24 hours after death.

To the Funeral Director: After this certificate has completely fifted in by the funeral director, page 2. Certification: To Medical

27. Manner of Death

4 Homicide

1 Natural 5 ☐ Pending investigation 2 Accident 3 Suicide

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 2-13-98

0955 " 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes

28d. Describe how injury occurred 28f. Location Vitreet and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner atated. 29a. Certifier (Check only one) 29b. Signature a

29c. License number OCME

29d. Date aigned (Month, Day, Year) FEBRUARY 14,1998

e of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Dete filed (Month, Day, MAR 0 4 1998

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Ramer eorg Feb 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore N/A M Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Yaar 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplaca (State or Foreign Country) Days Hours 1₩ 2□F 212-26-3379 68 Vrs AUG. 4. 1929 Ohio Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. N/A Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1151 Ward Street 21230 USA 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indian, Stack White etc. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Datas; 1 ☐ Yes 2 ☐ No Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/industry (Spacify only highest grade Elementary/Secondary (0-12) College (1-4or 5+) Chauffer Baltimore City 11 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) John Franklin Cramer Doris Rose Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Grace Cramer - wife 1151 Ward St., Balto., Md. 21230 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 3/05/98 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Md. Meadowridge Mem. Pk. 21. Signature of Funeral Service License 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., Elkridge, Md. shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1. Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24s. Was an autopsy 1 □ Yes 2 □ No 25. Was case referred to medical late of Death (Check only one) 1 Yes 2 No 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

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filed within 72 hours aftar

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Pages 1 end 2 should I

21215-0020

Maryland

Baltimore,

Box 68760,

Division of Vital Records, P.O.

The law requires that the death certificate

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Physician/Medical py Completed Be (2 Certification: illed in by the

within 24 hours a To the Funeral C the 2

State Registrar

Medical

Other: 4 Nursing Home 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending Invastigation 1 Yes 2 Accident 3 Suicida 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyaiclan: To the best of my knowledge, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. Licensa number

29d. Date signed (Month, Dey, Year)

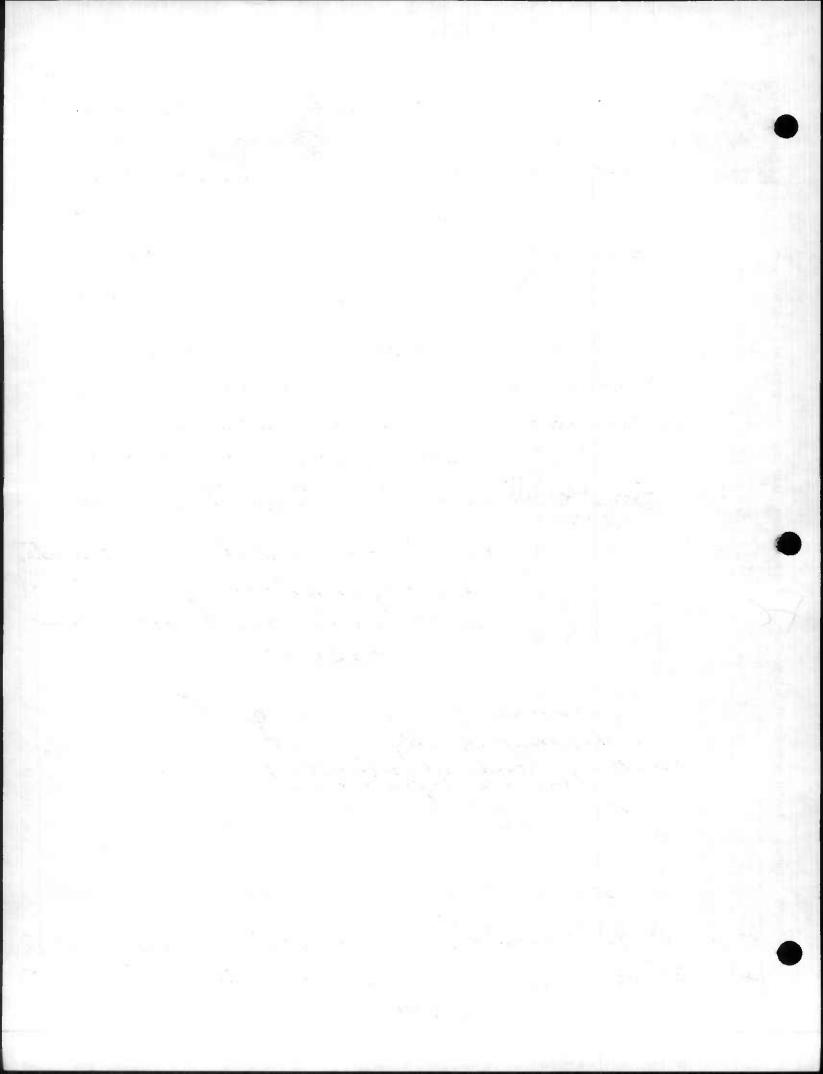
and address of person who completed causer of death (ttem 23a) (Type, Print)

LEACOCK MD 4820 SCTON 30. Name

DRIVE SCTON

29b. Signature a

32. Registrar's Signature

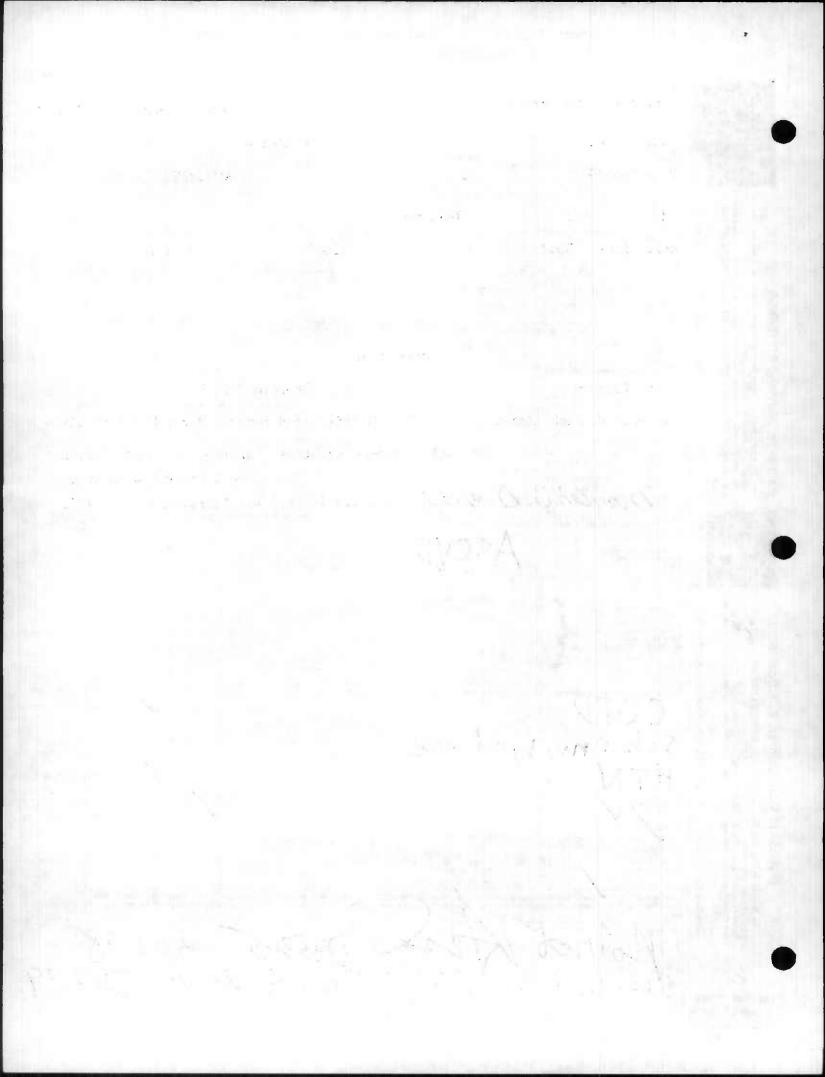


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Estelle H. Mc Carron March 1, 11:45 AM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4418 Findlay Road Baltimore 5. Social Security Number Under 24 Hrs. 8. Dafe of Birth
(Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 N F Months Days Yrs. 216-07-3356 Director 08/13/1905 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any Injury or other traumatic event, the Medical Example not the notified and page. 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location MD N/A Baltimore 1 ☐ Yes 2 ☐ No Director 10e. Street end Number 4418 Findlay Road 10f. Zip Code 10g. Citizen of What Country? 21206 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: Specify: White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anton Vancura Theresa Svitak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence E. Buchheister 715 Dividing Road Severna Park, Maryland 21146 20b. Place of Disposition (Name of cometery, crematory or other place)
Holy Redeemer Cemetery 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 3/5/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name end Address of Fecility Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the waith. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner and I-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical Due to (or as a consequence of): signed by the al Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings aveilable prior fo completion of cause of death? 24e. Was an eutopsy Completed ny syndrome certificate has b 1 Yes 2 DNo 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice director. 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pasidence 8 Other (Specify) 2000 Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natúral 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil Medical 29a. Certifier and manner 29b. Signature and tiple of certifier 29d. Date signed (Month, Day Year) 29c. License number 6 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar



Item: 19b Per FH Film G-757 3-4-98RC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9/An DY ring /Medical 4c. County of Death (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** Joseph Ritchie Hospice Baltimore n/a 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□ M 20XF Director Yrs 217-90-4445 30 May 10, 1967 Maryland Usual Rasidence of Decedent the Meryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow must be notified at Director 1 TyYes 2 □ No MD n/a Baltimore 10e. Straat and Number 10f. Zip Code 10g. Citizan of What Country? ò Herns 23a 3102 Westmount Court deeth , 21216 Funeral USA 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner filed within 72 hours efter of Hygiene. 1 ☐ Nevar Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: **Black** Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State of Maryland Elementery/Secondary (0-12) College (1-4or 5+) . Peges 1 end 2 should be filed w tment of Health and Mental Hygier tant: If Item 27 Is marked other th jury or other traumatic event, the 2 years Nursing Assistant Dept of Social Services 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be John McManus Mabel Macklin 19a. Informant's Name/Relationship (Typa, Print) mother 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD. 3102 WESTMOUNT COURT 822 North Augusta Ave. Mabel Macklin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removal from State permit. Pege Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Mar 3rd | Baltimore County, MD Arbutus Memorial Park 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funerel Service License 2501 Gwynns Falls Pkwy Baltimore, MD 21216 Em Baltimore, MD Part1. Enter the disaasa, or complications that days if the shock, or heart failure. List only one cause of each line the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, Approximete Interval Between Onsat and Death **Physician** 2/2 YOAKS /Medical Immediate Cause (Final AIDS disaase or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner physician end the buriel-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Diseasa or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): P.O. Box 6876 The law requires that the death certificete be Physician/Medical the Due to (or as a consequence of): been signed by the should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were autopsy findings available prior to completion of causa of death? Be Completed 24e. Wes en eutopsy performed? page 2 1 ☐ Yes 2 TNo 1 ☐ Yes 2 ☐ No certificate al or Attending Physician: T s efter death. II Director: After this certificet ed in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) axaminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not ba 3 ☐ Suicide 28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide

Division of Vital To the Hospital or within 24 hours eff To the Funeral DI completely filled in

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN B MACGIBBON MD, 101 W. READ ST SUITE TA BALTIMORE MD 21201

31. Date filed (Month, Day, Year) 4 1998

29b. Supering and title of certifier

29a. Certifier

32. Registrar's Signature

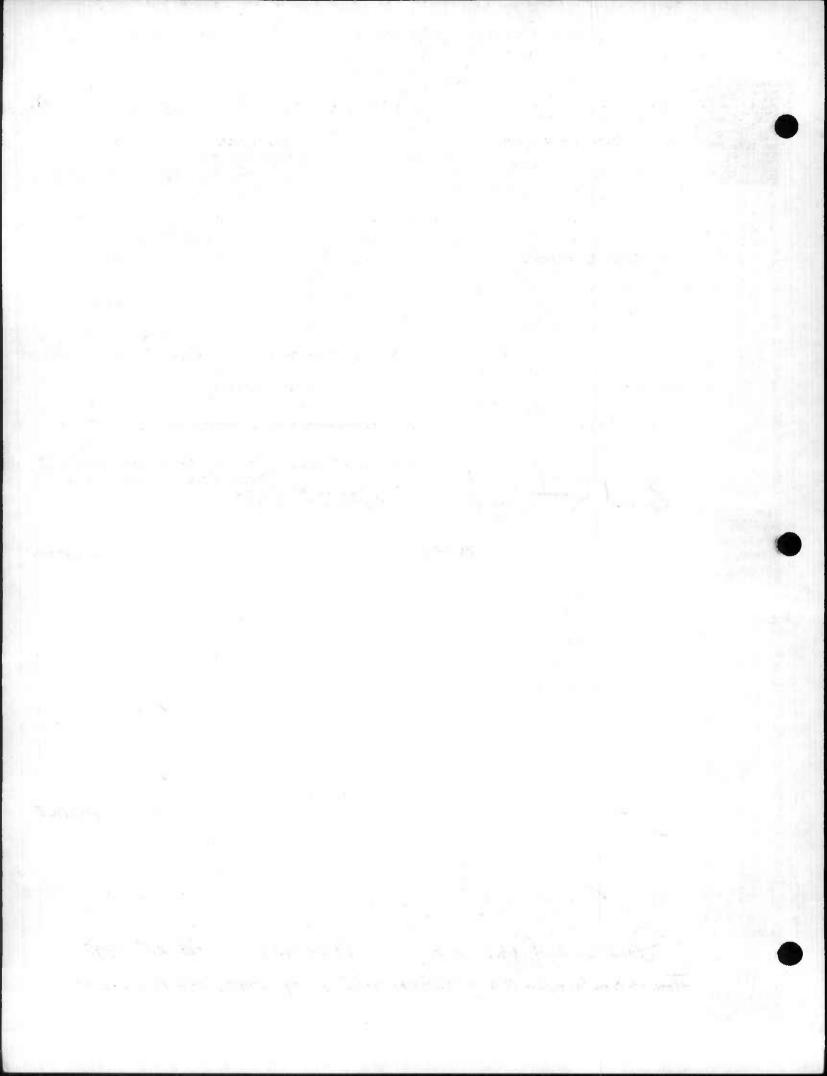
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1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the besis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 440 Donald Ray Coffey, Sr. rebruary /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner General 405 taltimore Baltimore Maryland
5. Sociel Security Number If Under 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 120M 2□ F Yrs. 186-68-2852 Usual Residence of Decedent 10e. Stete 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Franklin Chambersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3527 Sycamore Grove Rd. 17201 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Never Married 200 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specity: Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done duning most of working life. DO NOT use retired) 16b. Kind of Busineas/Industry Elementery/Secondary (0-12) College (1-4or 5+) Construction Painter 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) John Coffey Alice West 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3527 Sycamore Grove Rd., Chambersburg, PA 17201 Patricia Washabaugh Coffey-wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete 12 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Feb 28, 1998 Chambersburg, PA Norland Cemetery 22. Neme end Address of Fecility 11824 Reisterstown Rd Eline Funeral Home Reisterstown. MD 21136 in or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. espiratory Failure

Due to (or as e consequence of):

nterstitial rulmonary Fibrosis Immediate Cause (Final disease or condition resulting in deeth) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last eumo coniosis Due to (or es e consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco usa contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospital: 1 Inpatient 10 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manufer of Deeth Certification: 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office bullding, etc. (Specify) 4 Homicide edicai 29a. Certifier 1 🗹 Certifying Phyeiclen: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted. 2 Medical Exeminer: On the besis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and menner stated. 29b. Signature end title of certifing 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) syland General Hospital Saijad HZiZ, M.D. Go 827 Linden Ave. Balto, md 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture

State Registrar

Funeral

Director

28a-f show

"natural", or items 23s

Department of Health and Mantal Hygiene. Important: if item 27 is marked other than any Injury or other treumetic event, the Many ones.

Physician

/Medical

Examiner

physician and the bunal-tran

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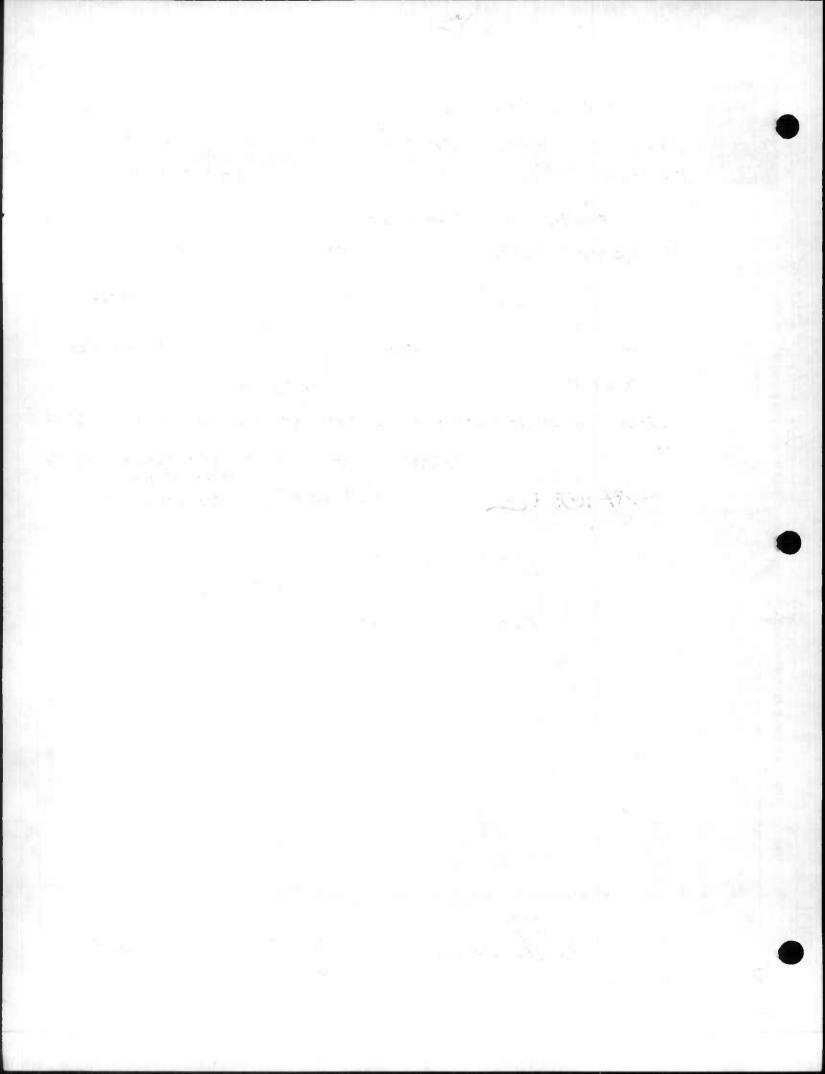
To the Hospital or Attending Physician: The law requires in within 24 hours after death.

To the Funeral Director: After this cartificate has been sign completely filled in by the funeral director, page 2 should be

P.O. Box 68760

Records,

Division of Vital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Ellen L Cooke toprunru /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Gilchrist Center, GBMC Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Deys Hours Min. | 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplece (Steta or Foreign Country) 6. Sex **Funeral** 1□M 20 F Director 218-40-0334 58 Oct.4,1939 Maryland Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Directo Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 108 West 39th Street Funeral Apt.30 U.S.A. 21210 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indien, Bieck, White, etc. Never Marriad 2 ☐ Married 1 ☐ Yas 2 No Spacify: à Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within 7 all Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 4 Case Worker Dept.of Juvenile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be permit. Pages 1 end 2 should be fa Department of Health and Mental It Important: If item 27 is marked of eny injury or other traumatic even 12 should be fi 9 Clark B. Cooke Doris Herth 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2-G Baldwin Court Catonsville, MD 21228
se of Disposition (Name of Date 20c. Location - City or Town, State Clark B Cooke, Father Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Buriai 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/2/98 Woodlawn, MD Lorraine Park 22. Name end Address of Fecility Witzke Funeral Home, Inc. 21. Signeture of Funeral Service Licensell 1630 Edmondson Ave Catonsville MD 21228 23a. Part 1. Enter the disaase, or complication shock, or heart feilure. List only one card at causad the daath. Do not enter tha moda of dying, such es cardiac or respiretory errest, on each line. Approximete Intervei Between Onsat and Daath **Physician** /Medical immediata Ceuse (Finel endo metro ol month disease or condition resulting in deeth) Examine Due to (or es e consequance of) Examiner physician and s the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of). Box 68760 Physician/Medical Due to (or es e consequence of): ed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed be should be deta Records, by 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed complation of cause 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes cese referred to medical exeminer? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No this 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. tnjury et Work? or Attending Patter death. Affer 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not ba 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 2 4 Homicide within 24 hours of To the Funeral Di completely filled in the Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of centiles 29c. License number 29d. Data signad (Month, Day, Yaar) February 27, 1898 no 30. Name and address of person who completes cause of death (ling 23e) (Type, Print)

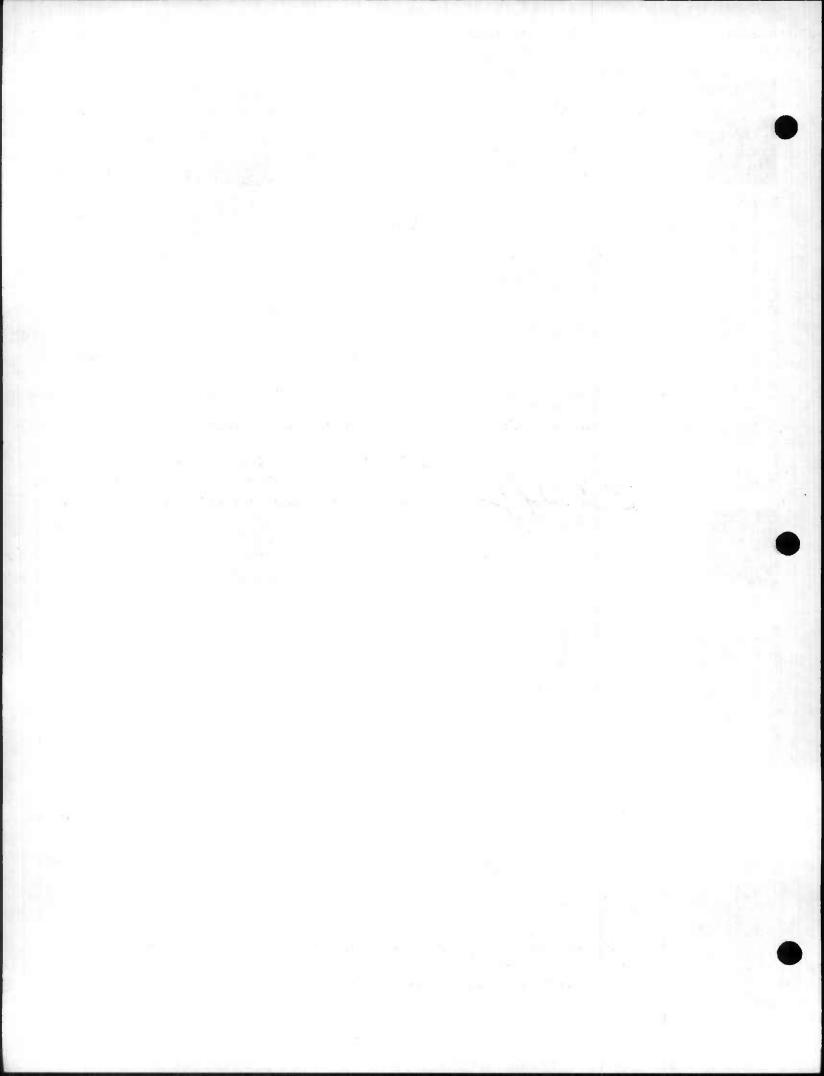
State Registrar 6-Bme

31. Date filed (Month, Day, Yeer)

6700

32. Registrer's Signeture

N. Charles Str Bolto, md 21204



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 3/3/98 repertificate of Death Reg. No. 24a, 25, 26, 27 3. Tima of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** FRANK CHERRY 1, FEBRUARY 1998 2:45 AM /Medical 4e Fecility Neme (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 11XM 2□ F Months Deys Hours Min 261-37-5113 Yrs. 58 June 25, 1939 unknown **Director** Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or items 23s or 28s-1 show any Injury or other traumstic event, the Medical Exemination must be partial. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director unknown unknown unknown unknown 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? unknown unknown unknown Funeral 12. Wes Decedent Ever In U.S.
Armed Forces? Unknown
1 □ Yes 2 □ No
If Yes, Give
Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Ves 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be unknown unknown 0 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20b. Piece of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 □ Donetion 5 ☑ Other (Specify) in state 21. Signeture of Funeral Service Licenses Royald S. Wader State Anatomy Board, 655 W. Baltimre Street Director Baltimore, Maryland 21201

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician SEPSIS /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner PNEUMONIA hysician and the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. attending physician Physician/Medical Due to (or es e consequence of): usa as t Po P.O. 23b. Did tobacco use contribute to the cause of death? detached Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the signed by t 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS Division of Vital Records, à 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed CEREBROVASCULAR ACCIDENT paga 2 s has The certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No After this funeral 28b. Time of 28d. Describe how injury occurred 27 Menner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury et Work? 1 Naturel
2 Accident 5 Pending s after death. 1 Tyes 2 No investigation the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Cartifying Phyeicfan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steled.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner steled. 29e. Certifier Medical completaly (Check only one) within 2 the the 29b. Signature and tipe of certifie 29c. License number 29d. Date signed (Month, Day, Year) 98 D-37254 avo 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) BOON P. LIM, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204 Julian Williams Slottere 31. Dete filed (Month, Day, Year) State MAR 0 4 1998 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dey PM (1 CHAILDIN 11998 OHN . F. March 2 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth SYSTEM UNIVERSITY OF MARYLAND MEDICAL BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Months Devs 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 6 Sex 10-M 20 F Deys FEBURRY 22, 1925 PERINGYLUANIA 210-18-2577 Usuel Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MIDDLE RIVER MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? GROVETHORN RD 21230 U.S. A 358 12. Was Decedent Ever in U.S. Armed Forces? 1 Dries 2 □ No If Yes, Give Yeer or Detes: ₩ ↓↓ Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: WH TE 3 DWidowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) PoinT 8+1 CHIPPER SPARROWS nia 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Michael CHAILDIN MARY ZAJAC 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 2101 BUELL DR. FAIISTON, MD 21047 KUREK MRS MARYANN 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Deuriel 2 Cremation 3 Removal from State Dukney VAILEY CENETERY 3-6-98 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Milker Funeral Home 21. Signeture of Funerel Service Licensee Miller Harfold RD BALTO, MD 21234 7527 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart fellure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Organ System Palure Multiple Aterioscieros.s Due to (or es e consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evellable prior to 24a. Wes en eutopsy performed? completion of ceuse of death? 1 ☐ Yes 2 NO 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

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Attending Physician:

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Box 68760.

Division of Vital Records, P.O.

Physician

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7 is marked other than "natural", or itema 23s or 28a-f show treumstic svent, the Medical Examiner maint be notified at

Hygiena.

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Itam 27 is marked other than any Injury or other treumatic event.

the Marylend

death

72 hours efter

altimore, Maryland 21215-0020

Examiner Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury fhet Initiated events resulting in death) Lest Physician/Medical

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

25. Wes cese referred to medical exeminer? 1 Yes 2 No 27. Menner of Death

28e. Dete of Injury (Month, Day Year) 5 Pending investigation

Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Tes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Neturel

2 Accident

3 ☐ Suicide

4 - Homicide

Tartifying Phyalclan: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier

6 Could not be determined

29c. License number

MD

29d. Date signed (Month, Day, Year)

30. Name end eddress of parson who completed cause of deeth (Item 23e) (Type, Print)

D 28247

Greene ST. BOLTE, ND

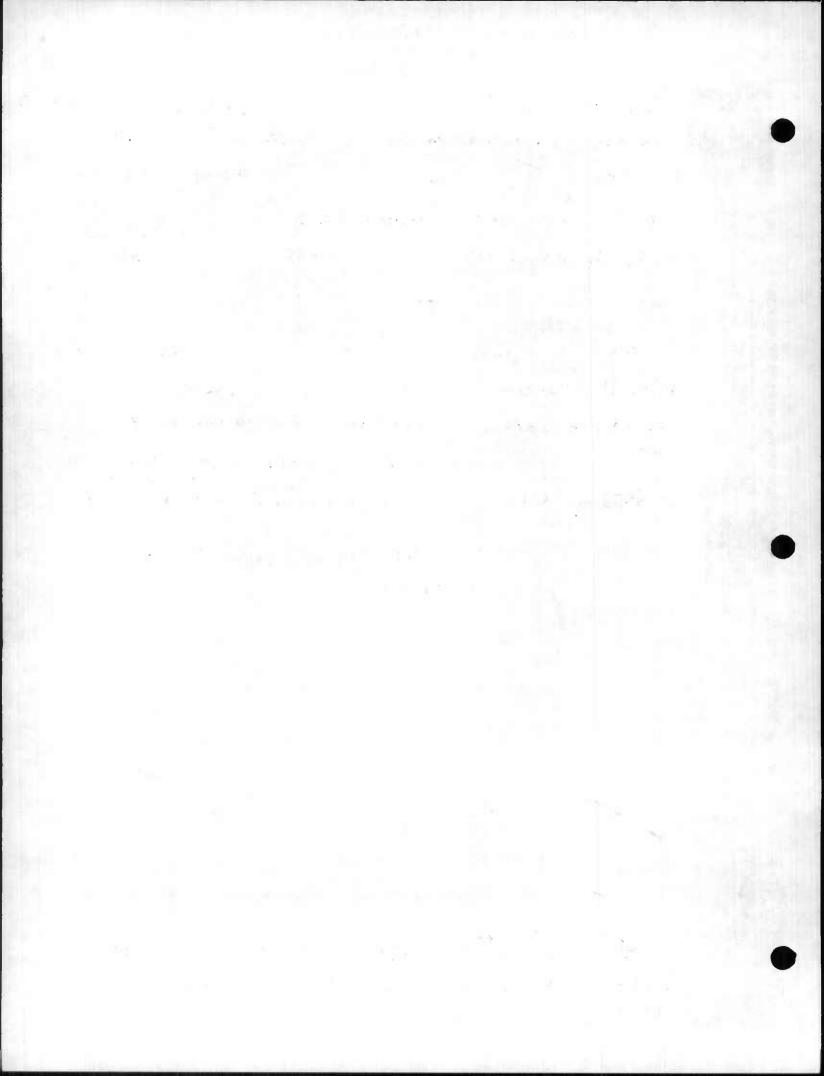
Keith Levitt

31. Dete filed (Month, Day, Year) MAR 04 1998

GF 32. Registrer's Signeture

university

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.™ 2. Data of Death 3. Tima of Death 1. Decedent's Nema (First, Middle, Last) Day 1998er **Physician** 2, Deickman, Jr. 11:00 a.m. E. March Frank /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Baltimore City N/A 1932 Heathfield Road If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** Days 1 X M 2 □ F 218-12-8773 95 Yrs. Baltimore, Md. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumstic event, the Medical Exercises. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Baltimore City N/A Director Md. 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code United States 21239 1932 Heathfield Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarlcan Indien, 11 Marital Status 1 ☐ Yas 2 🛣 No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Produce Sales Self Employed 18. Mothar's Nema (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Frank E. Deickman, Sr. (Not Known) Barbara 19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Baltimore, Md. 1932 Heathfield Rd. (Wife) Mrs. Mary H. Deickman 20b. Plece of Disposition (Name of cematery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stata Bel Air Memorial Gardens 3/5/98 Maryland Bel Air, 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Milton J Knigh 22. Name and Addrass of Facility LeonardJ. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part 1. Inter the disease, or conplications that the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on local new the control of the con Approximata Intarval Batween Onset and Deeth **Physician** Immadiata Causa (Final diseese or condition resulting in deeth) /Medicai **Examiner** Due to (or es a consequance of); Physician/Medical Examiner www physician and the burial-transit Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in daeth) Lest Due to (or es a consaquance of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): use signed by the a 23b. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware eutopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? certificate has b lirector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Wes case referred to medical examiner? Be 26. Piaca of Daeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28e. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of tnjury 28c. Injury at Work? Certification: or Attending 5 Panding 1 Yes 2 No 24 hours after death. invastigation 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Streat end Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifiar 1 🗹 Certifying Physician: To tha best of my knowledga, daath occurred et the time, date end place, end due to the ceuse(s) end mannar es steted. edicai completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred at the time, date and place, and dua to the cause(s) and mannar stated. within 2 To the 29c, Licansa number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifian

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Registrar

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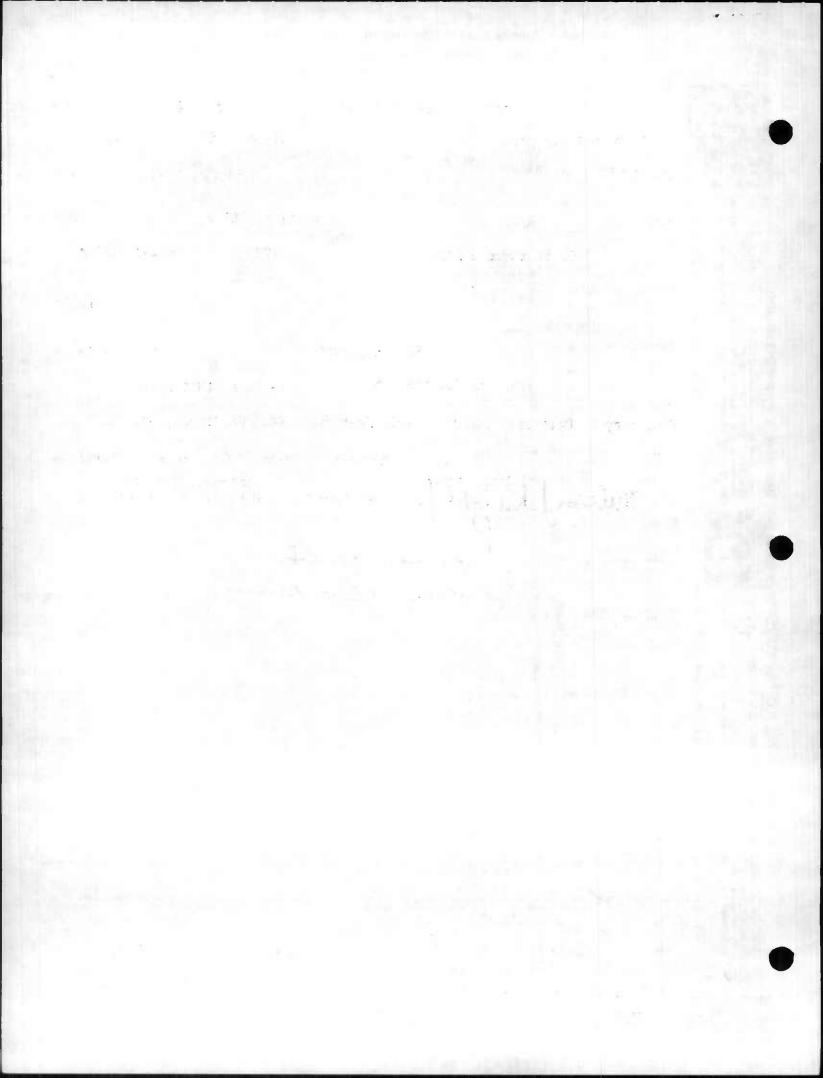
31. Date filed (Month, Day, Year) 329 Registrar's Signetura

30. Name and eddress of person who complated cause of deeth (Item 23e) (Type, Print)

an author MAR 0 4 1998

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 06650 Certificate of Death Rea. No. 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth Day Yaar Month David Alexander Donovan March 1998 12:23P 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, give street and number) Greater Baltimore Medical Center Towson Baltimore Birthplace (Stata or Foreign Country) If Undar 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthdey) XXM 2DF Hours Davs Months 215-07-6064 87 November 15,1910 | Maryland Usual Rasidance of Decedan 10d, Insida City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Coda 10a. Citizen of What Country? 13801 York Road 21030 USA 14. Race - Amarican Indien, 12. Wes Decedent Ever In U,S. Armed Forcas? XX Yas 2 □ No If Yes, Giva Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, atc.) 11. Merital Status Bleck, Whita, atc. 1 □ Nevar Married 2 □ Married 1 ☐ Yas X No Spacify: Specify: White ¾(□X Widowed 4 □ Divorced Yaar or Datas 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast greda complated) Elementery/Secondery (0-12) Collega (1-4or 5+) 5+ Banker Banking 17 Fathar's Nama (First, Middle, Last) 18. Mothar's Neme (First, Middla, Maidan Sumama) David Patrick Donovan Gertrude Boucher 19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) Susan D. Kirwan DTR 319 Hawthorne Road Baltimore, Maryland 21210 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, cramatory or other plece) Data 20c. Location - City or Town, Stata 1 A Burlal 2 Cremetion 3 Ramoval from Stata 4 □ Donation 5 □ Other (Specify) Mount Olivet 3/4/98 Frederick, Maryland ature of Funeral Servicell iconsec 22 Nama end Address of Fecility Mitchell-Wiedefeld Home Inc caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, acade death. Do not antar the mode of dying, such as cardiac or respiratory arrast, acade death. 23a. Part1. Entar tha disaase or conshock, or heert failure. List only Approximete Intarval Batwean Onset and Death Immediate Ceuse (Final disaasa or condition rasulting in daath) Acute Myocardial Infarction 10Min. Dua to (or as a consequence of): Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immadiata causa. Entar Undarfying Causa (Disaesa or Injury that initiated avants rasuiting in daeth) Lest Dua to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Dementia 24b. Wara autopsy findings availabla prior to complation of cause of death? 24a. Was an eutopsy performad? **Prostate Stones**

Physician /Medical Examine

Physician

/Medical

Examiner

10a. Steta

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Funeral

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7 is marked other than "natural", or items traumatic event, the Medical Examples in

Hygiene.

Pages 1 and 2 should be faced of Health and Mental I

Item 27

Department of Important: If any Injury or once. 田 高

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filed within 72 hours efter death

Baltimore, Maryland 21215-0020

physicial and is the burief transit 98 USB for ed by the e signed t should b

s certificate hes b funeral director, this After n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in

Examiner Physician/Medical by Completed Be

Attending Physician: death. ò

Division of Vital Records, P.O. Box 68760

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Registrar

Certification: To edical To the Hosp within 24 hou To the Fune completely fi

27. Mannar of Daath 5 Pending invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 4 ☐ Homicide Certifying Phyalcian: To tha bast of my knowladga, daath occurred et the tima, data and place, end dua to tha causa(s) and menner as statad. 29a. Cartifiai 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end menner stated. (Check only one) 29b. Signatura and titla of certifian

28a. Data of Injury (Month, Day Year)

29c. Licanse number D-44467

28c. Injury at Work?

1 | Yas 2 | No

29d. Date signed (Month, Day, Year) March 2, 1998

28f. Location (Straat and Number or Rural Route Number, City or Town, Stata)

1 Yas XX No

1 Yas XX No

28d. Dascribe how Injury occurred

26. Placa of Death (Check only one)

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify)

30. Nama end eddrass of person who complated cause of daath (Itam 23a) (Type, Print)

Hospital:

6569 North Charles Street Towson, Maryland 21204 Suite 708 Ronald Tutrone Jr

25. Was casa rafarred to medical

1 Yas 2 No

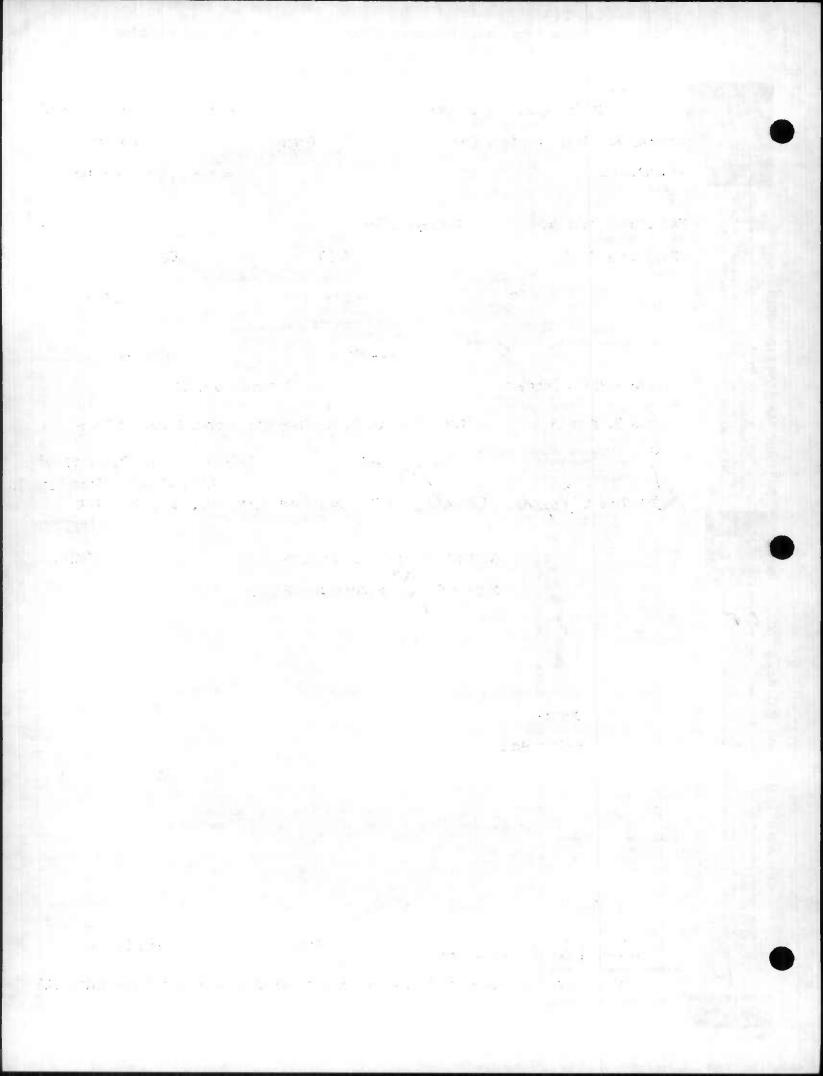
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1 X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28b. Time of

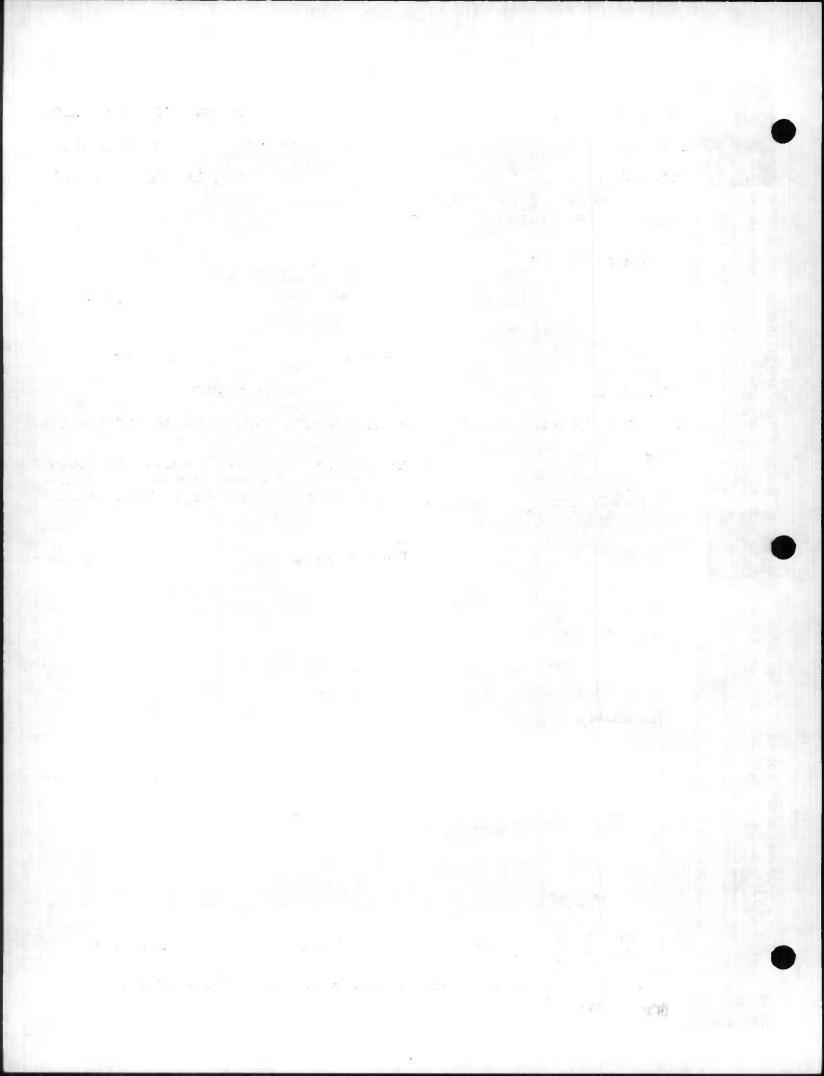
Hospital



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	ecedent's Name (First, Middle,	Last)						2. Date of Dea Month	th Day	Year 3.	Time of Death
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	acility Name (If n			umber)			4	b. City, Town, or Lo	FEBRUAR ocation of Death	Y 25, 4c. County	of Death	: ZUPI
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	ocial Security Num		. Sax	7. Aga (In yrs	s. last birthday)	If Under 1		If Under 24 Hrs.	8. Date of Birth (Month, Day			(State or Foreign
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MA]	Street and Numb	er				10f. Zip C	Code		1	0g. Citizan of V	What Country?	
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	□ Nevar Married		Armed F 1 1 Yes If Yes, G Year or	2 No Rive		Yes, specif		Specify:	Micen, etc.)	Specify	ok, White, etc. WHITE	
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	(Specify	only highest	grade completed		(Give I	ind of work	done d	during most of work	ing			
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TIRE!	se (Disease or Ini initiated events Iting in death) Las		c	Due to	(or as a consequ	uence of):						
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	Pretural ☐ Accident	5 Pending investigat		onth, Day Year)	Injury	М		Yes 2 □ No				
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27. h			aminar: On the					ne, date and place, pinlon, death occur				
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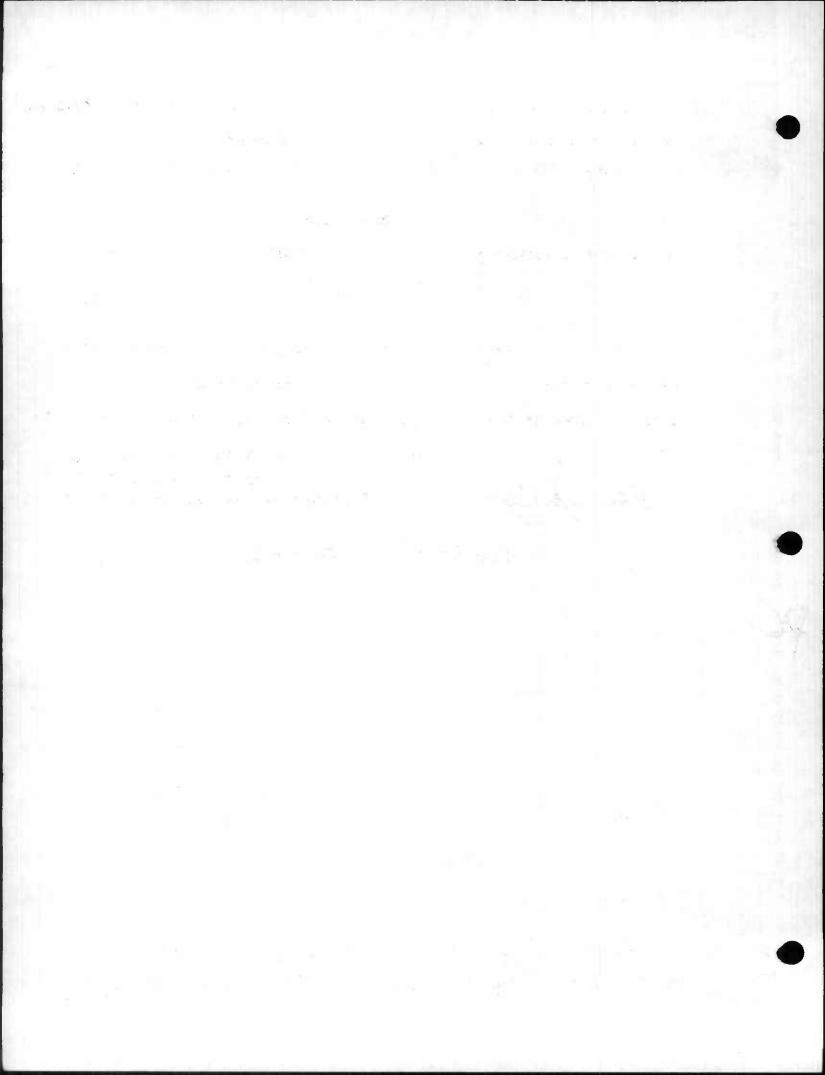


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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Physician March 02, 1998 8:15 an Isaac Lester Edwards /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 2558 Loyola Northway Baltimore N/A Hours Min. Jan 31, Year 1940 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country) NC . 7. Age (In yrs. last birthday) **Funeral** Deys 1 1 2 F 58 Yrs. 246-56-6901 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 No Director N/A Baltimore Md10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 2558 Lovola Northway Items 23a USA Funerai death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "naturel", or 1 Yes 2 No Specify: by Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If frem 27 is marked other than any Injury or other traumatic avant Elementery/Secondary (to 12th College (1-4or 5+) (0-12)City of Balto Parts Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Albert Edwards Bertha Grady 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Susie M. Edwards (Wife) 2558 Loyola Northway Baltimore, Md. 21215 20b. Plece of Disposition (Name of cametery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/07/98 Woodlawn, Md. Woodlawn Cem 4 ☐ Donation 5 ☐ Other (Specify) of Funarai Sanciaetta 22. Name and Address of Facility Caple Funeral Service 5502 Winner Avenue Baltimore, Md. 21215 1. Enter the disease, of complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final ATE CANCER diseese or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in deeth) Lest Due to (or as a consequence of): physician Physician/Medical Due to (or as a consequence of) P.O. Box 68 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 | Yes / ONDS 3 Probably 4 Unknown Records, þ Be Completed 24b. Were eutopsy findings aveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? page 2 s 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After s effer dec. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide • Funeral Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) end manner stated. To the Funer completely fi 29a, Certifier Medical To the To the To the 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) W) of death (Item 23a) (Type, Print) 46 grasspores of Outsloomers more no State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1 Decedent's Neme (First Middle Last) 2. Dete of Deeth Day March 02, 1998 RTTA ENGLISH **EASTMAN** 5:00 P.M. 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, giva street and number) Roland Park Place Baltimore 8. Data of Birth (Month, Dey, Year) If Undar 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplece (State or Foreign Country) Min Months Deys Hours 10 M 20 F 95 Yrs. 216-14-4411 March 24, 1902 Colorado Usuel Residence of Decedent 10a. State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 1 Vas 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 830 W. 40 th. Street 21211 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 🕅 No If Yes, Give Yaar or Detes: 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 N Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondery (0-12) 12 years College (1-4or 5+) Advertising Executive Advertising 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) English .Tames Agnes Quim 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Thomas Peter (Personal Rep.) 6436 Blenheim Road Baltimore, Maryland 21212 20b. Placa of Disposition (Nema of cametery, cremetory or other placa) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donelion 5 ☐ Other (Specify) 3-4-98 Baltimore, Maryland Green Mount Crematory 22. Noma and Address of Facility Mitchell-Wiedefeld Home, Inc. 21. Signeture of Funeral Servica Licansee 23a. Pert1. Enter the disease for complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21212 Approximete interval Between Onset and Death immediate Ceuse (Final disease or condition resulting In deeth) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated avents resulting in deeth) Last Due to (or es a consequence of) Dua to (or as a consaquance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to 24e. Was an eutopsy performed? complation of causa of deeth? 2 1 No 1 Yes 2 No 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 1 DNaturel 5 Pending investigation 1 Yes 2 No 2 Accident

Examiner Physician/Medical Examiner Pue P.O. Box 68760. The law requires that the deeth certificate Division of Vital Records. b should b Completed certificate has b lirector, page 2 sl the Hospital or Attending Physician: Be P this funeral Certification: After a Funeral Director: Aft bletely filled in by the fur within 24 hor To the Fune completely fi edical

Physician

/Medical

Examiner

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Director

r 28a-f show

I is marked other than "natural", or items 23s or traumatic event, the Medical Evantuer must be a

permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event. It is Medical Examples.

Physician

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altimore, Maryland 21215-0020

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25. Wes case referred to medical examiner? 27. Menner of Deeth 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

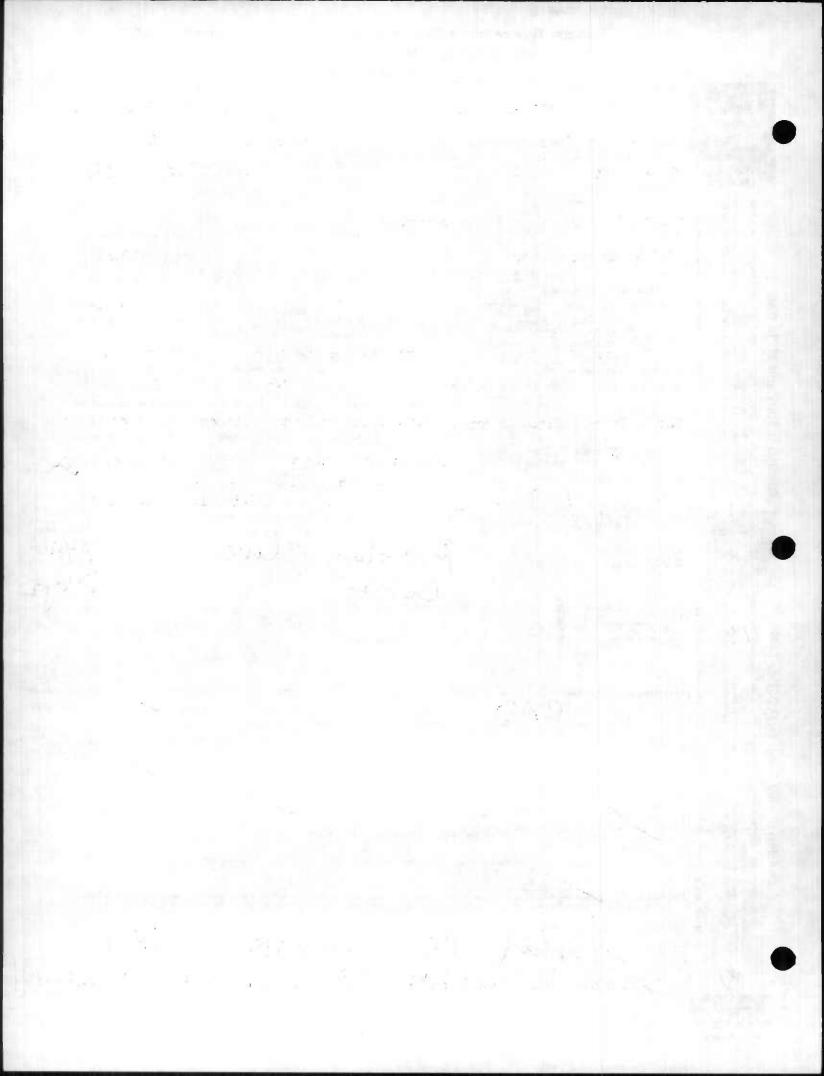
29b. Signature and title

29c. Licansa number 29d. Dete signed (Month, Dey, Year)

use of death (Item 23a) (Type, Print) 30. Neme and eddress of person wi

State Registrar 31. Date filed (Month, Day, Year) 4

32. Registrer's Signeture una Davidson-Gandale



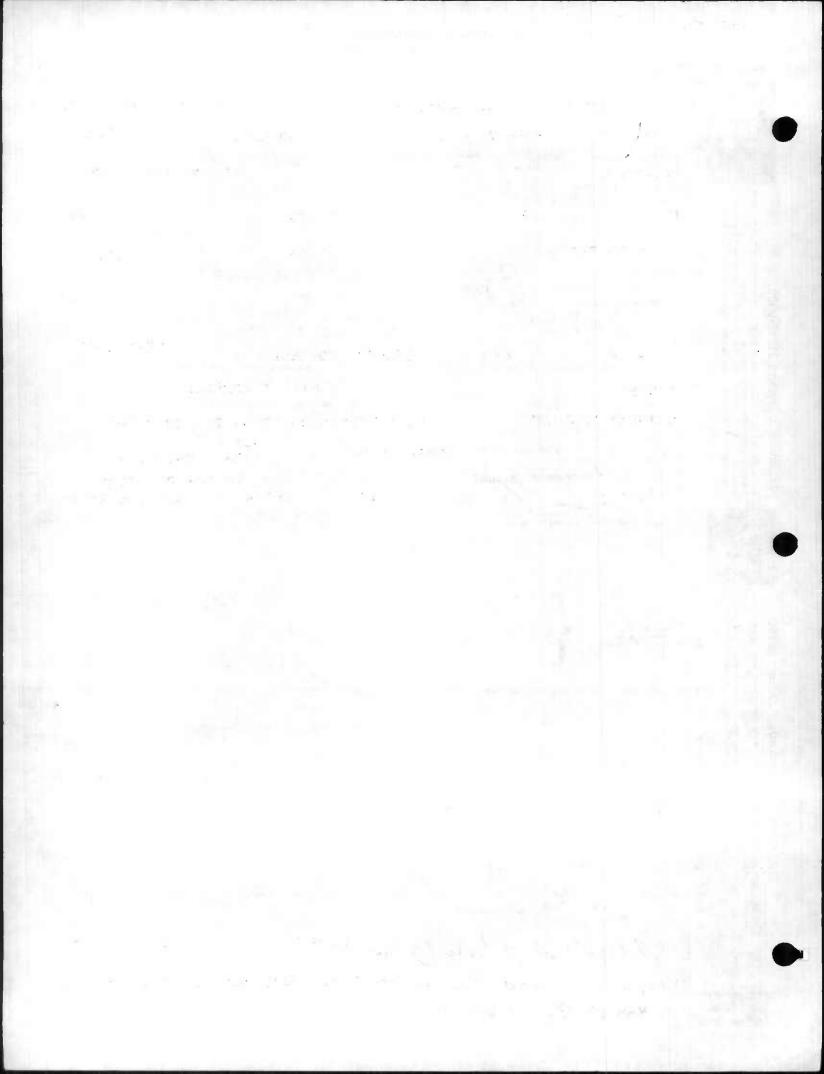
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State of Maryland / Department of Health and Mental Hygiene	98	OGGEL.
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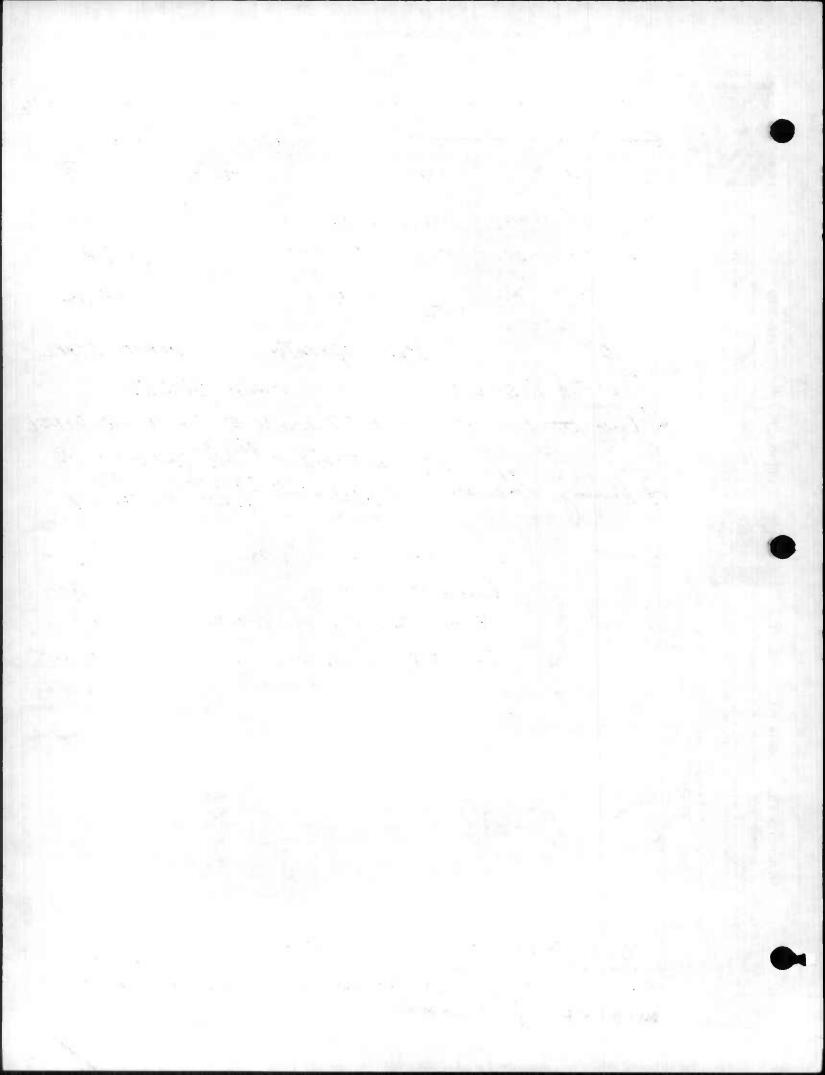
MAR U 4 1998



Item: 4ab Per MD Film G-757 3-4-98RC
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 9

1. 17	G-757 3/19/98 dh ecedent's Neme (First, Middfa, La	ist)		Certifica	ale of	Death	2. Data of Dec	Reg. No.		3. Time of Death
an	Leona		Eis	wert			Month	Dey	Year	9,00 /
ai er ^{4a}	acility Neme (If not institution, gir				ST.	b. City, Town, or I		4c. County	of Death	
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		Sex 1 M 2 F	Age (In yrs.	Month Yrs.	der 1 Year ns Deys	If Undar 24 Hrs. Hours Min.	8. Dete of Birt (Month, De	A STATE OF THE PARTY OF THE PAR	9. Birthpl Count	ece (State or Foreign (ry)
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	Merital Status I Never Married 2 Marriad I Widowed 4 Divorced	12. Wes Deceder Armed Force 1 Yes 2 [If Yes, Give Year or Dates	s? ∃No	If Yes, s	pecify Cubi	lispanic Origin? (S en, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		e - Amarica k, White, e	
	15. Decedent's E (Specify only highest gr	ducation ede completed)		16e. Decedent's U	work done	during most of wor	king	16b. Kind of Bu	siness/Ind	lustry
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	TOSEDH	EISWE	ERT			AN	WA B	LOSK	11	
198	. Informant's Name/Relationship			19b. Mailing Addr	ess (Street	end Number or Ru	iral Route Number	er, City or Town,	Stete, Zip	Code)
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20e	Method of Disposition 1 Buriel 2 □ Cremation 3 €	Removal from Ste		Place of Disposition (income tery, crematory)	Neme of or other ple	(0)	FEB 13	20c. Location -		
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							10	Yes 2 No		death? ∃Yes 2□No
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	2 ☐ Accident investigation	on		M	1 🗆	Yas 2 □ No				
	3 Suicide 6 Could not l 4 Homicide determined	200. Pieca of	Injury - At h etc. (Speci	ome, farm, street, fed fy)	ctory, offica		28f. Location (City or To	Street end Numb wn, Stete)	er or Rure	il Route Number,
298			of examina	owiedge, deeth occurration end/or investige						
27. 29a	. Signature and title of certifier				29c. Licens			29d. Dete signe		
	> Mala P	nelis	te	m 23e) (Type, Print) D 5601	D	00 509	53	Feb	12.	1990
	, VUVUVUVU	1000			, ,	- 0 - /	9		- /	1110
30.	Neme end eddress of person who	completed cause o	f deeth (Ite	m 23e) (Type, Print)				Ste 1709		

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First Middle Lest) 2. Data of Death Month 2: 55 au ELLEN EDWARDS February 26, 1998 PARY 4e. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death County of Deeth FAUSION If Under 1 Year If Under 24 Hrs. HOSPITAL HARFORD GINERAL - ALLSTON 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax Birthplaca (Stata or Foreign Country) 1□M 280 F Months Days Hours 219 40 7308 Yrs. AU6.3, 1941 MARYLAND Usuai Rasidence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 250 No HARFORD MARYLAM JARRETISVILLE 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 3603 NORTH FURNANCE KORD 48016 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, atc.) 14. Race - American Indien, Black, Whita, etc. 1 ☐ Yas 2 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowad 4 ☐ Divorced 15. Decedant's Education (Specify only highast grade complated) 16a. Dacedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry JARRETTSVILLE Elemantary/Secondary (0-12) Collaga (1-4or 5+) PHARMACY 12YRS. CASHIER -CLERK 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) FREDERICK PARTIO MARGARET DONOVAN 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 31084 19a. Informant's Name/Relationship (Type, Print) 3603 MORTH FURNANCE READ JARRETTSVILLE MO FRANCIS A. EOWARDS, IV. 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date FLB.28 Burial 2 Cremation 3 Removel from Stete 8991 LAISONE WINHSIH 4 ☐ Donation 5 ☐ Other (Specify) FALLTON, MARYLAND 21. Signature of Funeral Sarkica Liberised 22. Name end Address of Facility EVANSENERAL CHARSL-BILATR, P. R. 21000 3 NSWPORT DRIVE FORST HU MARYLAND 23a. Part1. Enter the disaase, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or raspiratory arrast, shock, or haart failura. List only one cause on each line. Immediate Cause (Final disease or condition rasulting in daath) Applic Shock Dua to (or as a consequence of): Ab dominal sepsion Due to (or as a consequence of): Sequentially list conditions, if any, laading to immediate ceuse. Entar Underlying Cause (Diseasa or injury that initiated avants rasulting in deeth) Last Wile mead of Dua to for as a consequence of): obdominal metostasis mall cell lung cancer à melestages Part II. Other significant conditiona contributing to death but not resulting in the undarlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Reginatory priluse

Physician /Medical Examiner

Maryland

Baltimore,

Box 68760

Records, P.O.

of Vital

The law requires that the death certificate

12 should be fi h and Mental h is marked off

Pages 1 and 2 s ment of Health an ant: If Nem 27 is: ury or other trau

Department of important: If any injury or once.

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

must be notifie

Examiner

by Completed Be

Physician/Medicai

Certification: To

edicai

al or Attending Physician: T s aftar death. I Director: After this certificat To the Hosping.
within 24 hours after deatr
To the Funeral Director:

FERNANDO 31. Date filed (Month, Day, Yaar) Registrar

25. Was casa referred to madicel examinar?

29b. Signeture end titla of certifier

5 Panding Invastigation

6 Could not be datermined

Fernando A. Alpado

1 Yes 2 No

27. Mannar of Death

Natural 2 Accident

3 Suicida

29a. Cartifier

4 Homicida

DELGNAO

28a. Data of Injury (Month, Day Year)

1 Yas 2 No

1 Yas 2 No 26. Place of Daath (Chack only ona)

Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 28d. Dascribe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

1 Certifying Phyeician: To tha best of my knowladge, death occurred at the time, date and place, and due to tha causa(s) and mannar as stated.
2 Medical Examiner: On tha basis of examination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and dua to tha ceuse(s) and manner stated.

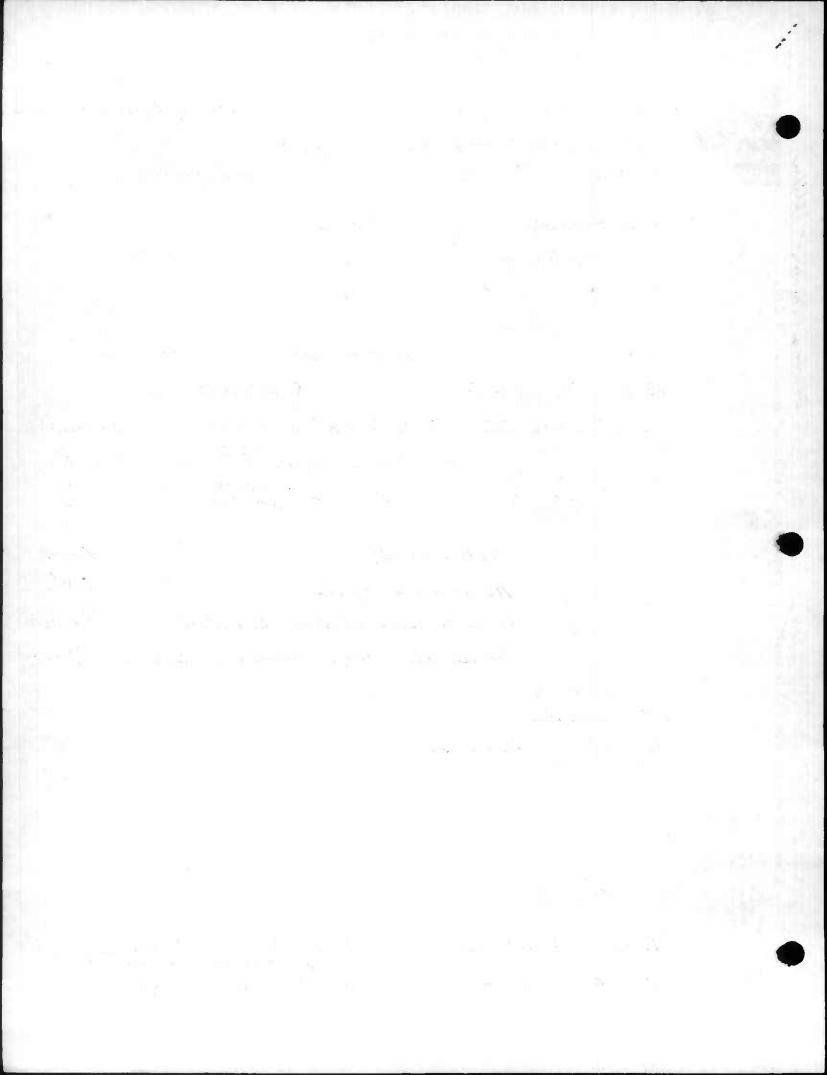
29c. License number 29d. Date signed (Month, Day, Year) 032717

30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print) OSL EN BOLIVE

32. Projestran's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

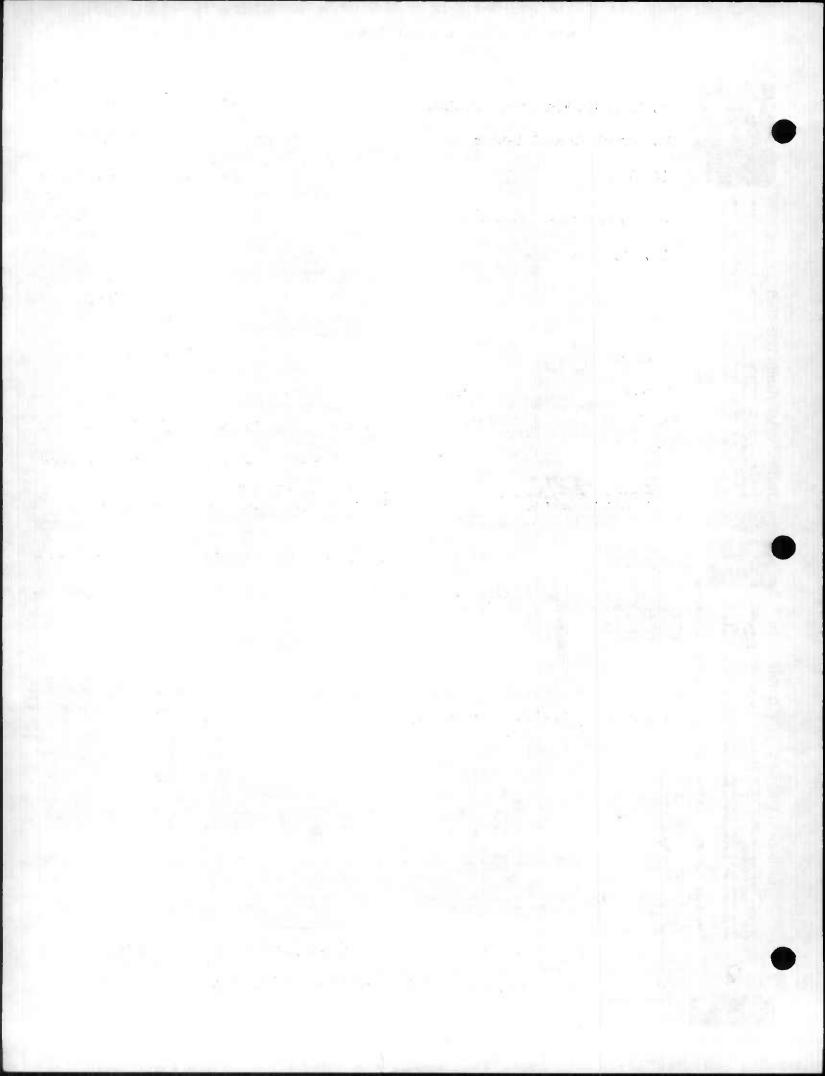
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	_	John					E	Illis		onth Muay	N 25.	1998	06
/Medica Examine		se Facility Name (If not institution,	give street and num	ber)	. 11			4b. City, Town	n, or Location		4c. County	-	
	L	THE JOHNS HOP	KINS HOSE	ΡΤΤΔΤ.				BALTIM	ORE CI	ГҮ	BALT	IMORE	
Funeral	5	5. Social Security Number 6	S. Sex	7. Age (In yrs.		(y) If Under	er 1 Year Deys	If Under 24 Hours	Min /M	te of Birth onth, Dey,	Year)	9. Birthple Count	ece (Stete or ry)
Director	1	220-74-5390	1⊈M 2□ F	33	Yrs.				Se	pt. 2	22, 196	4 unk	nown
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28a-f sho notfred at	5	10e. Street and Number				10f. Z	ip Code			10	g. Citizen of V	Whet Count	rv?
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9 2 2		19a. informent's Name/Reletionship Anna Ellis/wife									City or Town,		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) February 26, 1998 **Physician** Sr. M. Regis Finneran, M.H.S.H. 6:48 PM /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore St. Joseph Medical Center Towson If Under 1 Year Months Devs If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Funeral Min. Deys Hours 1□M 2₩F Director Nov. 23,1905 Rhode Island 214-74-4882 death with the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location 10b Counts 1 Yes 2 No Maryland Baltimore County r 28a-f Directo Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23s or 1001 W. Joppa Road 21204 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien 11. Marital Stetus Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene.
Interference of the marked other than "natural", or iteratural overs, the Medical Experients any or other traumatic event, the Medical Experient. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Nun 12 yrs Christian Ministry 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Thomas Finneran Marie 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mission Helpers of the Sacred 1001 W. Joppa Road, Towson, Maryland 21204 Heart 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from State New Cathedral Cemetery 3/3/98 Baltimore, Maryland 4 Donetlon 5 Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Segrica Licersee Martin D. Law Mitchell-Wiedefeld Home Lawson 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervel Between Conset end Deeth. **Physician** Immediate Ceuse (Final /Medical Cerebrovascular accident disease or condition resulting in deeth) Examiner Examiner Hypertension and Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) law requires that the death certificate Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? oronary artery Disease 1 Yes 2 No 3 Probably 4 Unknown signed l 2 24b. Were autopsy findings evellable prior to completion of cause of death? 24e. Was en eutopsy Completed certificate has b 1 Tyes 2 No 1□Yes 2□No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director. 25. Wes case referred to medical 8 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2♥ No funeral 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) in by 4 Homicide 24 hours s 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) end menner steted. 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier Louse D3832+ I Welsen MO 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 40RK ROAD, SUITE #18 LUTHERVILLE, MO21093 32 Registrat's Signeture Randale 31. Dete tiled (Month, Day, Year) State 0 4 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06659 Item: 7 per F.H. G-757 3/4/98 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Wesley Dev 7:00 PM Ferguson February 4e. Facility Name (if not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death LIBERTY MEDICAL CENTER BALTO 7. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 5. Sociel Security Number 2 1 8 - 0 7 - 5 4 7 3 Birthplece (State or Foreign Country) 1 XM 2 ☐ F VA Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No BALTO N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 U.S.A. 6210 FAIR OAKS AVE 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Raca - American Indien, Bieck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Stetus 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3℃ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 9 th College (1-4or 5+) TRUCK CO TRUCK DRIVER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) ALEXANDER FERGUSON ETTA UNKNOWN 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code $6210~\mathrm{FAIROAKS}$ AVE BALTO, MD 2121419e. Informent's Name/Reletionship (Type, Print) ELLA JACKSON 20b. Plece of Disposition (Name of cemetery, cremetery or other plece) MT • ZION CEM MAR 3 20a. Method of Disposition 20c. Location - City or Town, Stete Donetion 5 ☐ Other (Specify) BALTO, MD 21. Signature of Funerei Service Licensee 22. Neme and Address of Fecility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213 Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlec or respiratory errest, shock, or heart fellure. List only one cause on each line. · Cerebrovascular Accident 10 days Immediete Ceuse (Final disease or condition resulting In deeth) Due to (or es e consequence of): Pneumonia Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? Chronic Obstruction Pulmonary 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 2 No 1 Tyes 1 ☐ Yes 21 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

the Merylend

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Merylen Department of Heelth end Mental Hyglene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

sicial and burial-transit lew requires that the deeth certificate beans 88 signed by the a d be detached f certificate

DivIsion of Vital Records, P.O. Box 68760

Examiner

Certification: To

Physician/Medical

edical

To the Hospital or Attending Physician: within 24 hours eiter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 1

State Registrar 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No 1 Yes 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 UNeture 5 Pending investigation 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. 29e. Certifier (Check only one)

29b. Signeture end title of certifier

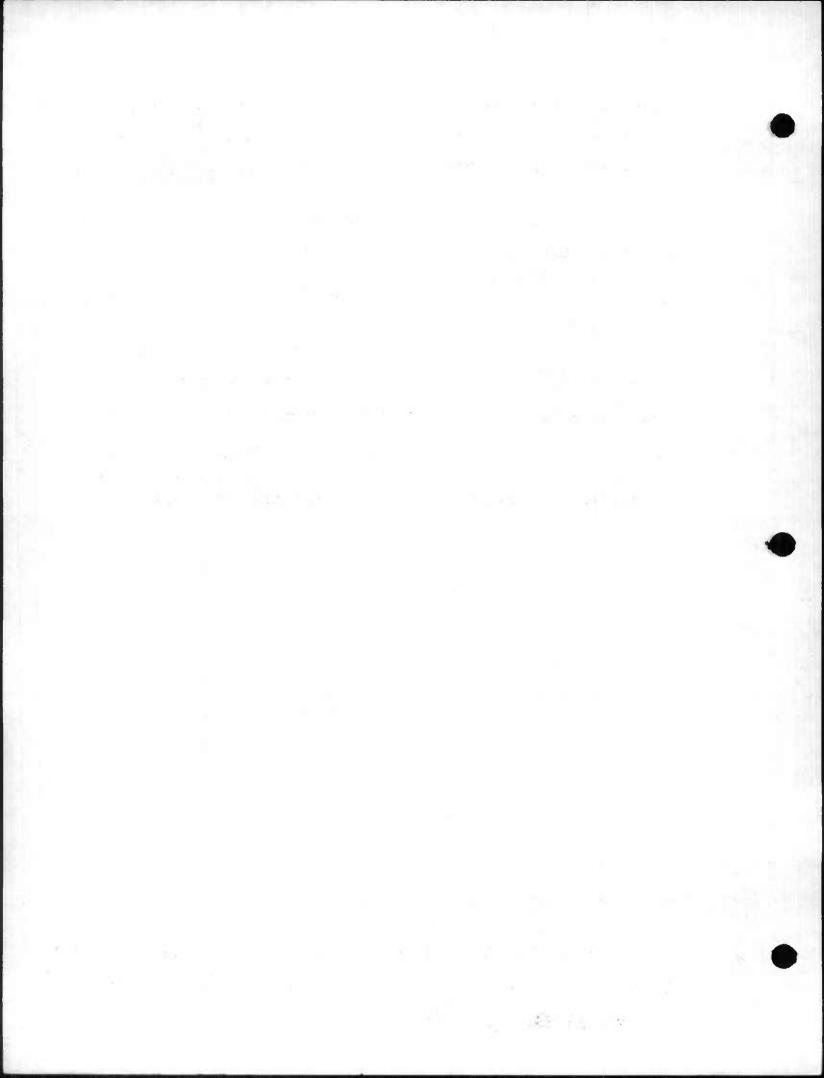
29c. License number

29d. Date signed (Month, Dey, Year) February 25, 1998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

2600 Liberty Heights Ave 21215

31. Dete filed (Month, Day, Year) MAR 0 4 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day **Physician** Robert William Frey February 24,1998 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not Institution, give street end number) 4c. County of Deeth Examiner Baltimore owson Cromwell Eldercare Genesis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociei Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Hours 100 M 2□ F Yrs. 213-34-6077 Usuel Residence of Decedent Director Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "nature" any injury or other traumatic executions. 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits arkville 1 Yes 2 No Baltimore Director Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21234 2803 Glavin Way - Apt. B U.S. A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (X) No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 2⊠No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S Posta Mailman 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be E. Frey Erma Kobert Kohler 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 10006 Crane Lane Baltmore, MD 21220 David Freu 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, State March 1 Buriel 2 ☐ Cremation 3 ☐ Removal from State Moreland Memoral Park 2,1998 ParkvilleiMD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility
Evans Chapel of memonis 21. Signeture of Edneral Service Licenses 800 Harford Rd. Baltimore, MD 21234 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Acrident Exe provasca /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as e consequence ot) Physician/Medical Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 6876 Due to (or es e consequence of) Ses for usa signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 | Yes 2 | No PV 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? s cartificata has t 1 ☐ Yes 2 No 1 □ Yes 2 □ No or Attending Physician: director. 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28e. Date of Injury (Month, Dey Year) funeral Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No daath. investigation 2 Accident after death 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 6 4 | Homicide filled in 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the Within 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year)
MAR 0 4 1998

Zind K

ear) July 32. Registrer's Signeture

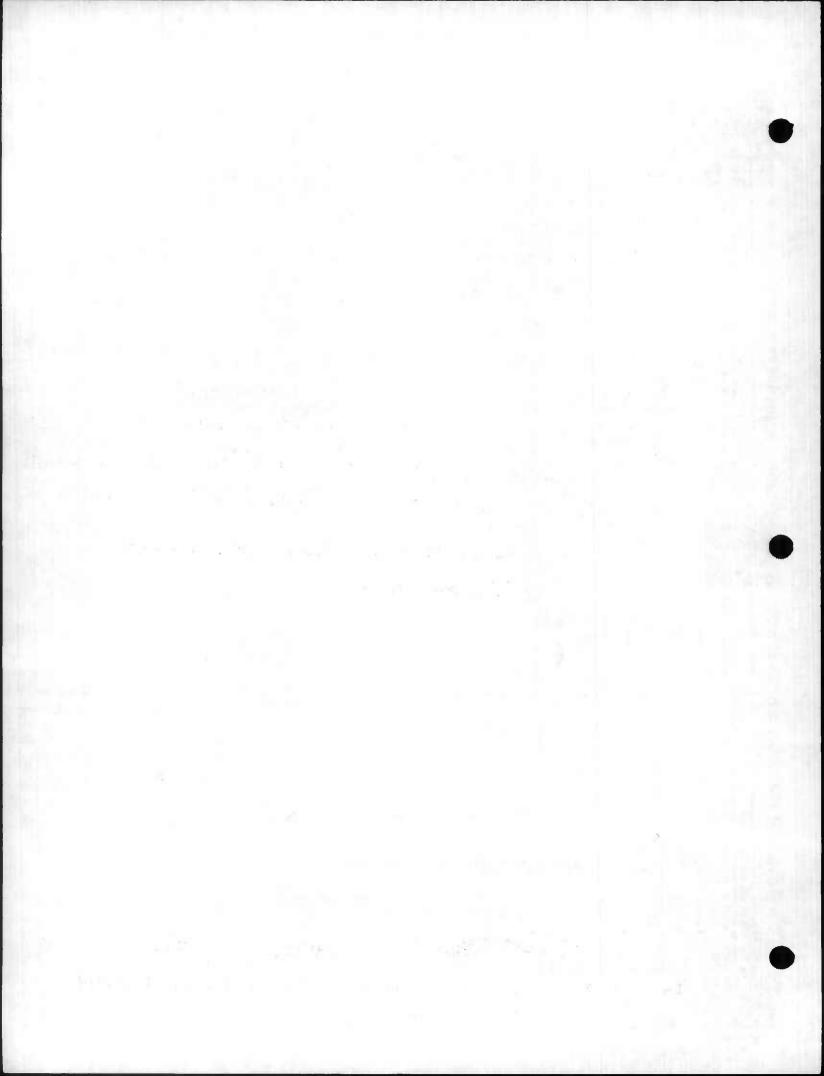
July 132. Registrer's Signeture

30. Name end address of person who completed cause of deeth (item 23e) (Type, Print)

Car

February 27,1998

Balto. MD 21214



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Year FLORENCE. MARCH 2, 1998 E. **FULMER** 3:00AM 4e. Fecility Name (If not institution, giva straet and numbar) 4b. City, Town, or Location of Daath 4c. County of Daath CATONSVILLE COMMONS CATONSVILLE BALTIMORE H Under 24 Hrs. Hours Min. NOV. 19, 1892 PENNSYLVANIA 5. Social Sacurity Number If Undar 1 Yaar 7. Aga (In yrs. lest birthdey) 9. Birthplece (Steta or Foraign 1□ M 2XF Deys Yrs 105 179-20-2209 Usuei Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No NORTH HAMPTON EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 709 CATTELL STREET 18042 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Nevar Married 2 Marriad 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) TEACHER **EDUCATION** 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) ALFRED REMALY MARY MANN 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) KATHY PEPPERMAN, GRANDDAUGHTER 308 MONTROSE AVENUE, CATONSVILLE, MARYLAND 21228 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremation 3 【Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) FORKS CEMETERY EASTON, PENNSYLVANIA 21. Signature of Funeral Service Licens 22. Name and Address of Fecility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 clused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, 23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o Immediate Ceuse (Finei disease or condition resulting in death) reunina ~ 10 days Dua to (or as a consequence of): Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Dua to (or as e consequence of) Due to (or es e consequance of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one)

Physician /Medical Examiner thet the deeth certificete be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

by

Completed

Be

7 is marked other than "natural", or itame 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at

markad other than

Peges 1 end 2 should be f nent of Health and Mental I nt: If Itam 27 Is marked of

permit. Peges 1 end 2: Department of Health ar Important: If Itam 27 Is any Injury or other trau

the Meryland

deeth

filed within 72 hours efter Hygiene.

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records,

Vital

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pue physician Physician/Medical the 98 ettending p signed by the e þ Completed page 2 Be Certification: To

1 Yas 2 No

5 Pending

Investigation 6 Could not be determined

27. Menner of Death

1 Naturel 2 Accident

3 Suicide

29a. Certifier

4 | Homicide

29b. Signature end title of certifier

within 24 hours
To the Funeral
completely filled

cal

Medi

State Registrar Keyor MI)

28e. Dete of Injury (Month, Dev Year)

29c. License number 127541

28c. Injury et Work?

1 Yes 2 No

10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to tha cause(s) end menner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

March 2, 998

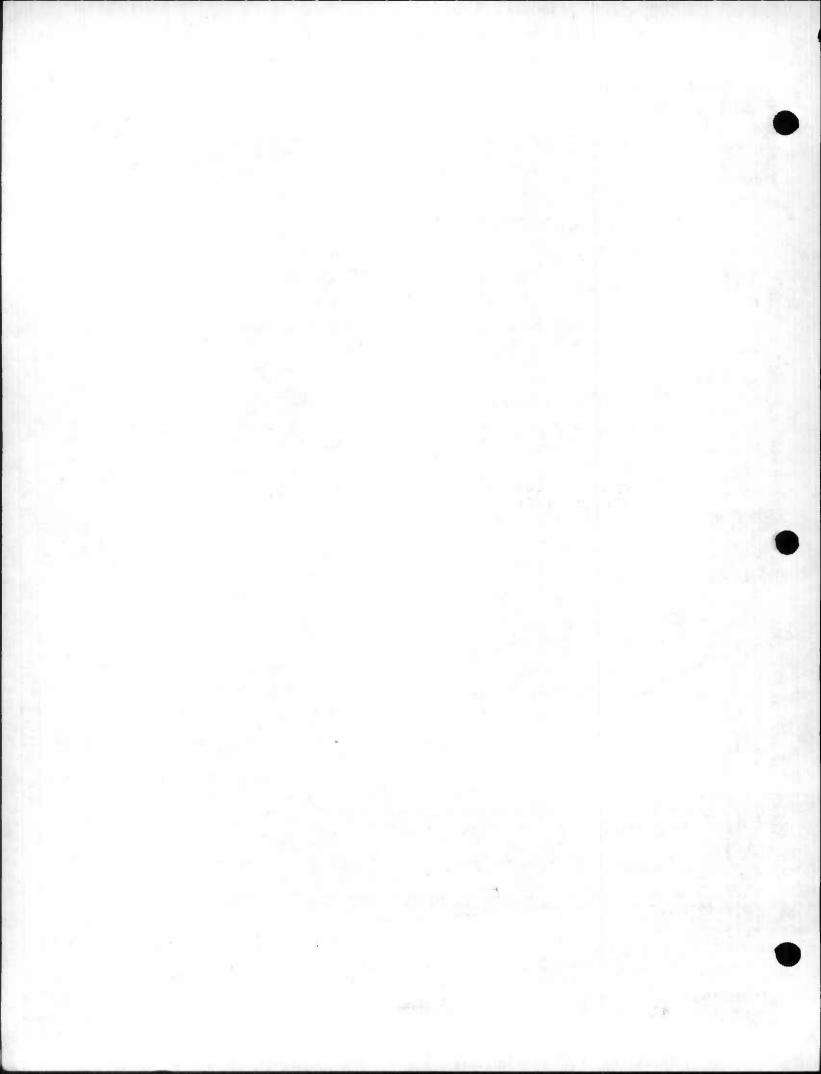
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FERRY RD, BALTIMORE, MDQ1RR7 31. Dete filed (Month, Day, Year)

NAR 0 4 1998 Jula Wayldon Hands 18

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

28b. Tima of



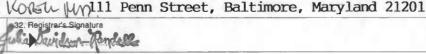
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene O LAWRENCE FREER Certificate of Death Items: 23a part I,27 per MEO G-757 3/9/98 dh 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 01, 1998 10:52 PM LAWRENCE M. FREER
4e Fecility Name (If not Institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner LAUREL REGIONAL HOSPITAL PRINCE GEORGES LAUREL If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XXM 2DF Months Deys Hours 47 Yrs Director 127-42-6067 Usual Residence of Decedar SEP. 20, 1950 NEW_YORK the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Nems 23s or 28s-f show traumatic svent, the Medical Examinat must be notified at 1 Yes 2 No Director MARYLAND HOWARD LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20723 U.S.A. 8819 BLUEBIRD TRACE death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 12 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) permit. Pages 1 and 2 should be filed within 72 hours effact beganning of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or the any injury or other traumatic event, the Medical Examinat page. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elemantary/Secondary (0-12) POLICE SERGEANT LAW ENFORCEMENT 18. Mother's Name (First, Middle, Maidan Sumama) 17. Fether's Name (First, Middle, Last) JOSEPH F. FREER SR. ROSEMARY MCMAHON 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 8819 BLUEBIRD TRACE, LAUREL, MARYLAND 20723 PATRICIA A. FREER altimore, 20b. Place of Disposition (Name of cametery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CRESTLAWN MEMORIAL GARDEN 3/5/98 MARRIOTTSVILLE, MARYLAND 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 21. Signature of Funeral Service Licensee 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 that the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, theart failure. Lift only one cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence of) Examiner physician end s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) certificate be exer Box 68760 Physician/Medical Due to (or as e consequenca of) 950 0 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? o 1 Yes 2 No 3 Probably 4 Unknown g Records, 24b. Wara autopsy findings evailable prior to completion of ceuse of death? 24a. Was an autopsy Completed peen has page 2 18 Yes 2 □ No 1 Nes 2 No Division of Vital director 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only ona) Yes 2□ No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how Injury occurred 28b. Tima of Certification: 28c. Injury at Work? After Attanding 1 XXVatural 5 Panding 1 Yes 2 No death. investigation 2 Accident after deat Director: 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide ò Hospital 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

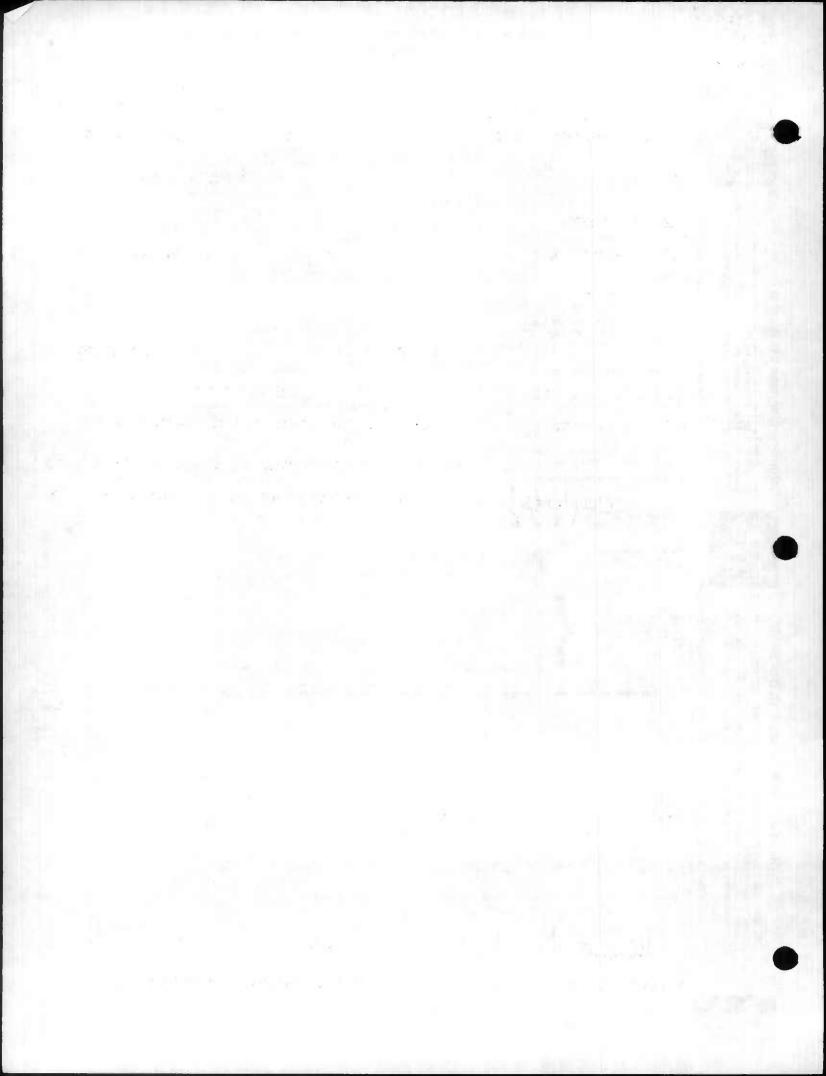
**Comparison of the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier edical To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 2, 1998 munte 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

MARYDAIN 31. Dete filed (Month, Day, Year)

MAR 0 4 1998





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by Funeral Director	10	De. Stefe MD	10b. County Baltimer	e City		Town or Location		10d. inside City L				
il Director	10	e. Street and N 38 West	lumber : Talbot S	treet		101. Zip Coo 21.2		1	Og. Citizen of V	Vhet Country?		
by Funeral			erried 2 Merried	12. Wes Decedent Armed Forces' 1 Tyes 25 If Yes, Give Yeer or Dates:	?	13. Was Decedent If Yes, specify (of Hispenic Origin? Cuban, Mexican, Pue No Specify:	(Specify Yes or No- erto Rican, etc.)				
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To Be C	17		e (First, Middle, Last,					eme (First, Middle, ne J. Rac		10)		
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Pauline J. adeliffe .alser J. Koosee

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 3. Time of Death 2. Dete of Deeth February 26, 1998 Month G:00pm **JAMES** GOODWIN 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE 7. Age (In yrs. lest birthday) If Undar 1 Yaar If Undar 24 Hrs. 5 Social Security Number Birthpleca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1□M 2□F Months Hours 230-50-4048 56 Yrs. JUNE 6, 1941 VIRGINIA Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits Yas 2 No **MARYLAND** N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2909 KIRK AVENUE 21218 U.S.A. 12. Wes Decedant Evar in U,S Armed Forces? Was Dacedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. Never Merried 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1□ Yes 2□No Specify: Specify: NEGRO 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER PRIVATE CO. 10TH 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) GIFFORD GOODWIN MARGARET BAILEY 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) SARAH BRODIE sister 3800 OLD YOUR RD. BALTO, MD. 21218 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stell 4 Donation 5 Other (Specify) VOSHELL MEMORIAL GARDENS MARCH 4,1998 BALTO, MD. 21. Signature of Funeral Service Licen-2. Nama and Addrass of Facility CALVIN B. SCRUGGS FUNERAL HOME 23e. Pert 1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21213 Approximete Intervel Between Onset end Death Immediate Cause (Final Broncho pnesmonia 24 hours disease or condition resulting in death) Enerephalo, malacea orobral 4ears 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Tyes 2 No carcinoma 24b. Were eutopsy findings eveilable prior to completion of causa of deeth? 24e. Wes en eutopsy performed? 12 Yes 1 Yes 2 No 2 No

Physician /Medicai Examiner

Physician

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Examiner

Director

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Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar mast be multiled at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If them 27 is merked other than "natural", or flar any Injury or other traumatic event.

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g physician and es the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initieted avents resulting in death) Lest Physician/Medical

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Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

32 Begistrar's Signeture V

26. Plece of Deeth (Check only one)

25. Wes cese referred to medical examiner? 1 ☑ Yes 2 ☐ No 27. Manner of Deeth

1 ☑Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) investigation

28b. Time of

28a. Piece of Injury - At home, farm, straet, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yas 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Naturel

2 Accident

3 Suicida

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner es stated. 2 Medicel Examiner: On the basis of axamination end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) and menner stated.

29b. Signeture and title of certifier

5 Pending

6 Could not be determined

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

Dance I Symonds, Pept of Lat

Lab Medicino's

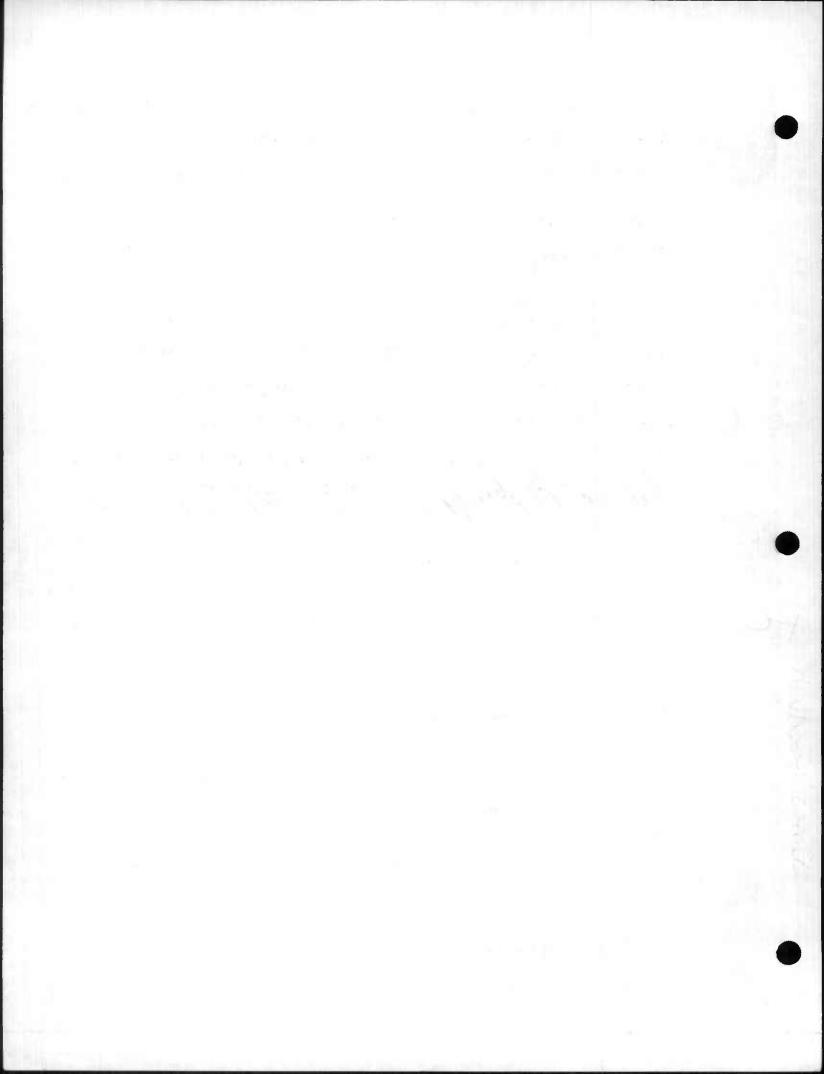
Union Memorial
201 E University
Baltimore MB

28f. Location (Straet end Number or Rural Route Number, City or Town, State)

Registrar

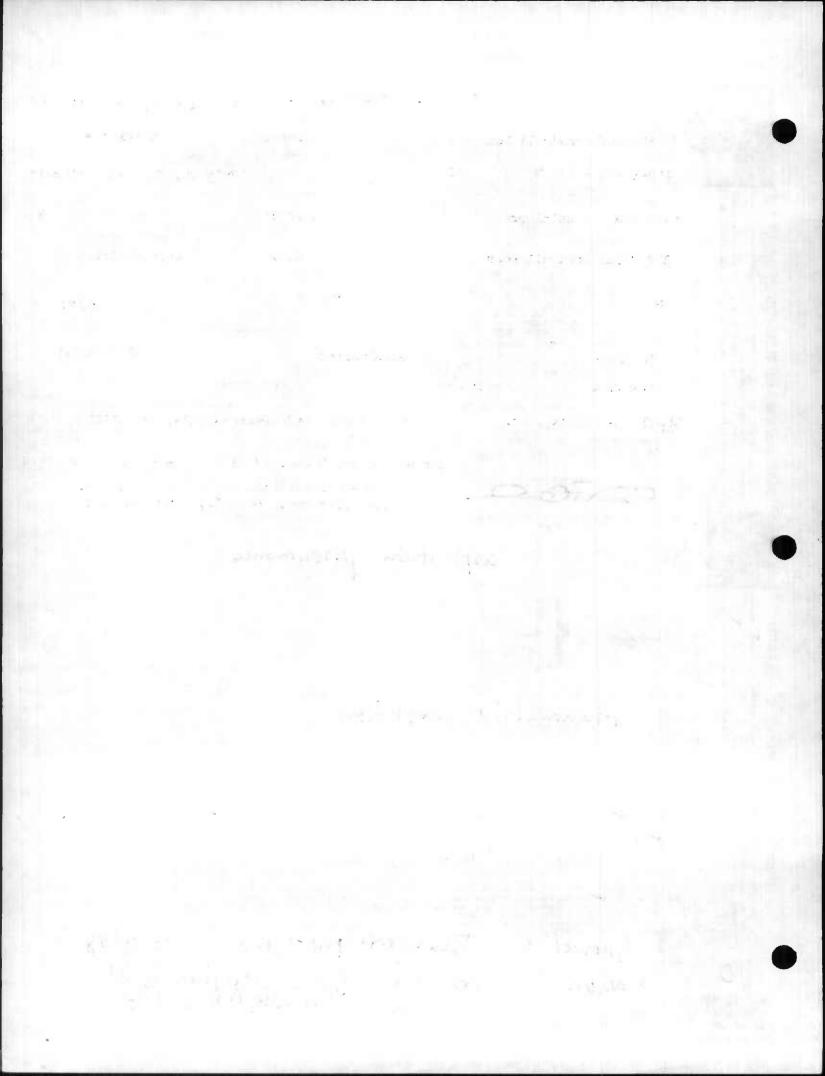
death.

To the Hospital or within 24 hours eft To the Funeral DI completely filled in



State of Maryland / Department of Health and Mental Hygiene 8 06665

					Cer	tificate of i	Death			Reg. No.			
Physic /Medi		Decedent's Name (First, Middle, La	Char	les J.	Gr	udinsky,	Sr.		2. Date of De Month Februa	Day Day 28,	1 ⁹ 98	3. Time of Death 1:29 AM	
Exami		Ab City Town of Lot								ation of Death 4c. County of Death Baltimore			
Funeral Director		183-12-4204	Sex 7. 1 № M 2 □ F	Aga (In yrs. last I	Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da July 2	th y, Year) 29,1914		elace (State or Foreign ntry) nsylvania	
ter death with the Maryland thems 23e or 28e-f show ther must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Bal	timore	10c. City, To	wn or Lo		Dunda	lk			1	0d. Inside City Limits 1 ☐ Yes 2 No	
the notif	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of V	Whet Cour	ntry?	
3a or		217 South Woodw	ell Road				2122	2		United	Stat	tes	
5-0020 72 hours efter death with the Maryland natural; or Hems 23a or 28a-f show sical Examiner must be notified at	by Funeral	11. Merital Status 1 □ Never Merrled 2 □ Married 3 ৺Widowed 4 □ Divorced	12. Was Deceda Armed Force 1 Yes 2 If Yas, Give Yaar or Date	1	Vas Decedent of H f Yes, specify Cuba I ☐ Yas 2(No	lispanic Ori an, Mexicar Specify:	n, Puerto	ecify Yas or No Rican, atc.)		ce - American Indian, ick, White, etc. 'y: White			
vithin 72 hours ena. than "natural",	Completed	(Specify only highast grade complated) Elementery/Secondary (0-12) College (1-4or 5+) 10 Years 17. Father's Name (First, Middle, Last)				lent's Usual Occup kind of work done o DO NOT use retired	ation during mos d)	t of work	ing	16b. Kind of B			
Maryland d 2 should be file the end Mental H fr 1s marked out traumatic even	Be					elworker	18. Mothe		e (First, Middle,	Stee Maiden Suman		dustry	
	To	Not Known 19e informant's Name/Relationship Charles Grudinsky	(Type, Print) S	-		ng Address (Street	and Numb	er or Run	al Route Numb		State, Zip		
		20a. Method of Disposition 132 Burlal 2 Cramation 3 I 4 Donation 5 Other (Speci	Removal from Sta	ate ceme	of Dispo tery, cren	sition (Name of natory or other plea	ce)	1	Date	ate 20c. Location - City or Town, State			
Baltimore, permit. Pages 1 en Department of Heat Important: If item 2 any injury or other		21. Signature of Funeral Service Lice		Garo	22 D	Nama and Addreso Ouda-Ruck 1922 Wise	ss of Facili Fune	ral	Home of	Dundal	k, In		
Physician /Medical · Examiner	6	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediata Cause (Final disease or condition resulting in deeth)		sed the death. Dh line.	o not ente	er the mode of dyin	ng, such es	cardiac	or respiratory a	rrest,	1 1 1 1	Approximete Interval Between Onsat and Death	
OX 68 / 60, certificate is incured anding physician and usa as the burishment	n/Medical Examiner	Sequentially list conditions, if any, leading to Immadiete ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest	b	Due to (or as									
hat the death of by the atterdeted for	Physician	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. When a ford arthur fix								23b. Did tobacco use contribute to the cause of			
COTOS, requires been sign should be	Completed by								24a. Was	an autopsy ormed?	av	ere autopsy findings allable prior to emplation of causa death?	
The lay ate has page 2	E								10	Yes 22 No	1 [□Yas 2□No	
ysician: Thysicians is certificate director, par	Be	25. Wes case referred to medicel examiner?					26. Place	e of Deet	h (Check only	one)			
Of VITa Physician: this certific ral director,	2	1 Yes 2€ No	Hospital: 1 ☐ Inp	atient 2 ER/	Outpatien		4 LINI	ursing Ho	oma 5 4 Hesi	dence 6 □Oth	ner (Specif	(y) .	
After fune	Certification:	27. Manner of Death 1	on	Day Year)	o. Time of Injury		yat rk? Yes 2□	No		how Injury occur			
Vital or Att		4 Homicide determined	28e. Place of building	, etc. (Specify)		eet, factory, office			City or To	wn, State)		al Route Number,	
DIVISION To the Hospital or Attend within 24 hours after dealt To the Funerel Director: completely filled in by the	Medicai	(Check only 2 Medical Exa	hyalcian: To the be miner: On the basi and manner	s of examinetion		estigation, In my o	pinion, dea			date and place,	and due t	o the ceuse(s)	
To To To Con	-	29b. Signature and title of certifier Amuel	C.	Durs	on	29c. Licens	+70	140	2	29d. Data signe	3/9	8	
10		30. Neme and address of person who	completed cause	of death (Item 23s	(Type,	Print) SE	٥٥	W	alth	er B/	vd.		
Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 4 1998	fully .	Jamanas Signatur	andel	e Pa	rkv	iller	14)	2123	4		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima of Deeth 2. Dete of Daeth 9 26, 1998 Month FREDERICK 720 February 4c. County of Death 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth Baltimore Samaritan Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 2 | 100 5. Soclei Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 12 M 2□ F 20 8046 72 Yrs. 1925 Usual Rasidance of Decedent 10b County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 1 No Baltimore SPATKS MATYLAND 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 16626 21152 USA Grove 14. Race - Amaricen Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑Yas 2 ☐ No Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 11. Maritai Status 1 Navar Married 2 Married 1 ☐ Yas 2 Z No Specify: Yas. Giva White 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highast grade complated) 16a. Dacadant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT use retired) Elementery/Secondary (0-12) Collaga (1-4or 5+) Bethlehem Steel Mill Right 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Buettner H. Avaust MATGATEL 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Streat and Number or Rural Routa Numbar, City or Town, Steta, Zip Coda) Gers HAZEL Sparks 21152 16626 Cedar Grove Rd. Maryland 20b. Place of Disposition (Neme of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State February 29 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, Maryland breenmount Cemetery 1998 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility chapel of Chimes EVAMS 2325 York K 21093 23a. Part1. Entar tha disaasa, or complications that ceused the daath. Do not antar tha mode of dying, such es cardiac or raspiratory arrast, shock, or heart teilure. List only ona cause on each line. Approximeta Intarval Batween Onset and Death Immediata Cause (Final maliquan diseasa or condition rasulting in death) cardio myo pathy defery (Oronany Dua to (or es e consequance of): 23b. Did tobacco use contribute to the cause of deeth? 3€ Probably 4 Unknown 1 Yes 2 No 24b. Wara autopsy findings eveileble prior to 24a. Was an autopsy performed? complation of cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

212

10a. Steta

Funeral

Director

28a-f show

Director

p

Completed

r than "natural", or items 23s or 28s-f shore the Medical Exerient must be notified at

filed within 72 hours after Hyglana.

permit. Pages 1 and 2 should be filed wit Department of Haelth and Mental Hygiana Important: if Item 27 is marked other tha any injury or other traumatic event, that, once.

Baltimore, Maryland 21215-0020

physician Physician/Medicai the 88 attanding I signed by the a cata has been sig this certificata

Records, P.O. Box 68760

Division of Vital

The law requires that the death certificate

Be Completed by

To the Hospital or Attending Physician: within 24 hours effar death.

To the Funeral Director: After this certifics completaly filled in by the funeral director, I

1+1

Sequantially list conditions, if any, laading to Immadiata ceusa. Entar Undarlying Ceuse (Disaasa or injury that initiated evants rasulting in daath) Lest Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. diabetis wellity type alterio sclesoris cerebrovascula 1 Yas ZANO 25. Was cesa refarred to medicel axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Impatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2DNo edical Certification: To 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred 5 Panding investigation Matural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 I Homicida 29a. Cartifier

TE Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and place, and dua to tha cause(s) end mennar es stated.

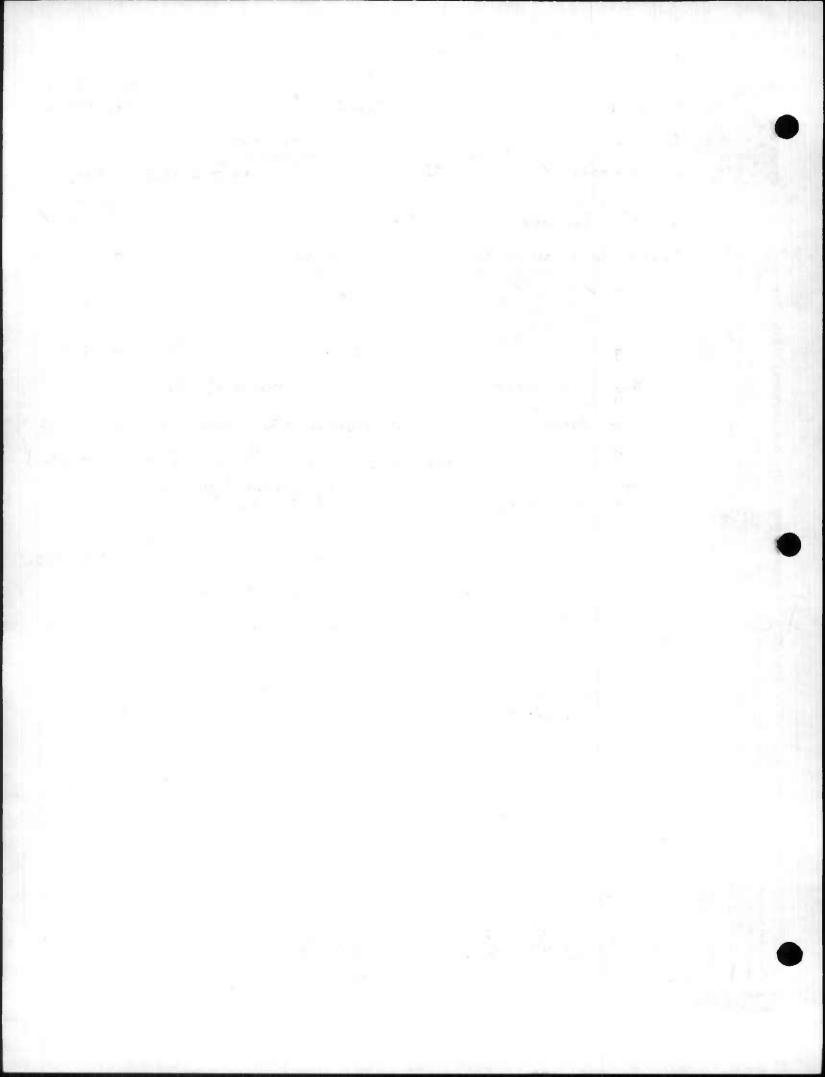
2 Medical Examinar: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, dete end place, and dua to the cause(s) end mennar stated. 29b. Signatura and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Yaer)

1 ☐ Yas 2 No

30. Nama and eddrass of parson who completed ceusa of daath (Itam 23a) (Type, Print)

Good Somer: ton Hospifal, 5601 Loch Karen Blvd, Bultimon, MD 21 Cathing Walter, 31. Dete filad (Month, Day, Year) 32. Ragistrar's Signature

MAR 04 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 05:27Am March 01 1998 GLORIA GLORIOSO 4b. City, Town, or Location of Death 4e. Facility Neme (If not Institution, give street end number) 4c. County of Deeth GILCHRIST HOSPICE TOWSON If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) Deys 1□ M 2X F Yrs 216-18-7142 Usual Residence of Decedent 74 JUL. 31, 1923 MARYLAND 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes ZNO MARYLAND BALTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Bleck, White, etc. 2500 GEHB AVENUE 21227 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritai Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 34 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) JOHN MUNROW MARY (UNKNOWN) 19e. Informent's Neme/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 206 ROLLING BROOK WAY, CATONSVILLE, MD 21228 GLORIA M. AMENT, DAUGHTER 20e. Method of Disposition Buriel 2 □ Cremation 3 □ Removel from State 20b. Piace of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Other (Specify) NEW CATHEDRAL CEMETERY 3/4/98 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. Thouse 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Onset and Deeth ischemic cardiomyopathy Immediate Ceuse (Finel diseese or condition resulting in deeth) years Artery disease Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes an eutopsy performed? 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICe 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

and physician å certificate 분

Examiner Physician/Medical þ Completed Be Certification:

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after death and Mental Hygiena.

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum once.

Physician /Medical

Examiner

altimore, Maryland 21215-0020

with the Maryland

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth

5 Pending Naturel investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28a. Dete of Injury (Month, Dey Yeer)

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Excertifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

N. Charles Ste Balto. Md

29e. Certifier (Check only one) 29b. Signature and after of pertition

· ws

29c. License number 025205

29d. Dete signed (Month, Dey, Year) MArch 1, 1998

end eddress of person who completed cause of death (flor 23a) (Type, Print)

A. R. Ley G. B.M.C. 670(31. Dete filed (Month, Dey, Year)

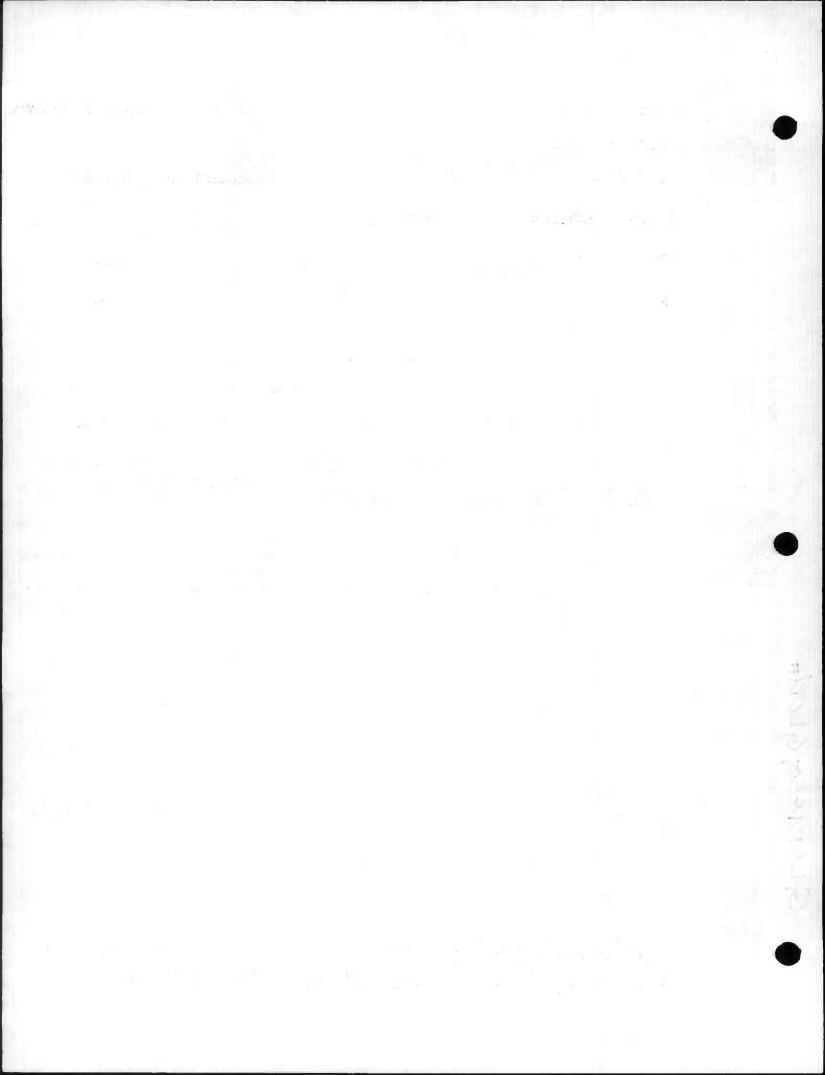
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182 Registrar's Signature

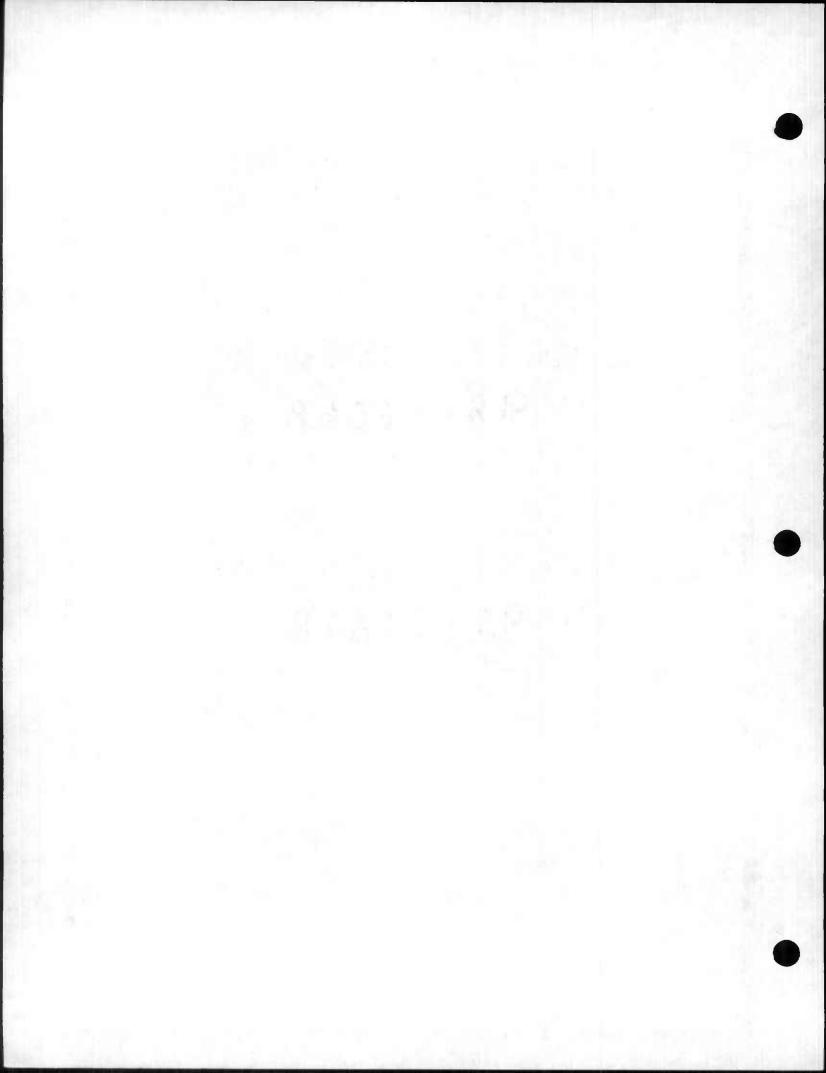
State Registrar

Medical

22



VOID
CERTIFICATE #
98-06668
SEE
CERTIFICATE #
91-DEATH



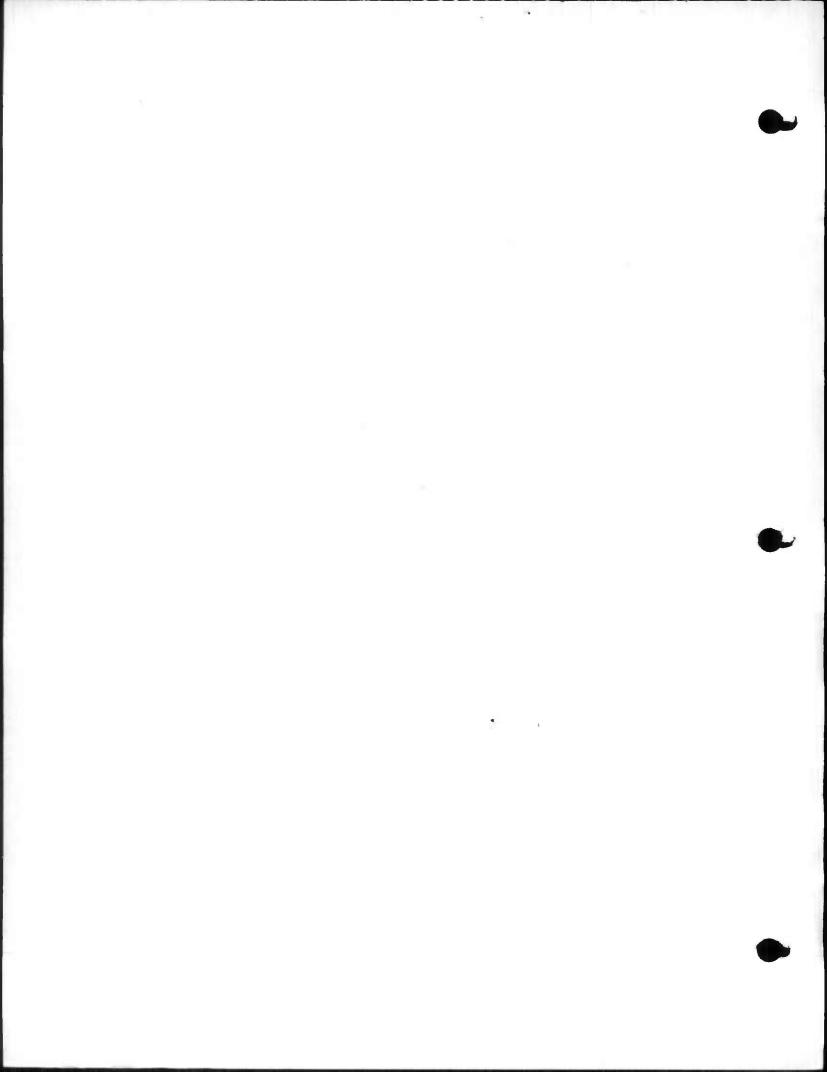
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

**O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	ECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director; page 5 should be detached for use as the burda-transit permit, Pages 1, 2, 3 should	rs after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	n 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIA	TO THE FUNERAL DIRECTOR: After this cert	be filed within 72 hours after death with the	IMPORTANT: If item 28 is marked, o	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR			CI	ERTIF	ICATE	OF	DEAT	TH		REG. NO.			
	1. DECEDENT'S NAME (FIRST		lor							MONT	of DEATH DA		YEAR Q	3. TIME OF DEATH 1:42 D M
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. las	t hirthday)	IF UNDER	1 VEAR	IF UNDER	24 1000		OF BIRTH	199		IPLACE (State or Foreign
	235-18-9298		1 🗌 M 2 💢 F	80	YRS.	MONTHS	DAYS	HOURS	MIN.	Octo	h, Day, Year)	1917	Countr	γ)
~	9a. FACILITY NAME (If not in	stitution, give stre	eet and number)			96. CITY,	TOWN C	R LOCATIO	ON OF DE	ATH		9c. COUR	NTY OF D	EATH
DIRECTOR	241 Marylan	d Aven	ue			Hancock Washington					on			
Ñ.	10a. STATE	10b. COUNTY			10c. CIT	y, TOWN O	R LOCAT	ION						10d. INSIDE CITY LIMITS?
	MD	Washii	ngton		Ha	ncoc	k							1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER	-						ZIP CODE				10g. CITI	ZEN OF V	YNAT COUNTRY?
띪	241 Marylan	d Aveni	ie.					21750)			US	Α	
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.AR	MED		WAS DEC	ENDENT O	F HISPAN		1? (Specify Yes		14. RACE	- American Indian,
	1 Never Married 2		IF YES, GIVE W	YES 2 🚫 I	NO			cify Cuba 2 XNO			Rican, etc.)	I	Speci	r, White, etc.
B	3 Widowed 4 Divo	rced						21				[White
COMPLETED		EDENT'S EDUCA y highest grade o		(G	CEDENT'S	vork done o			a	16b	. KIND OF BUS	INESS/IND	USTRY	
9	Elementery/Secondary (0	1-12)	College (1-4 or 5 +	His	. Do NOT us	e retired.)				1				
MP	8			As	semb1	er					rcraft		ufac	ture
8	17. FATHER'S NAME (First, M							16. MOTH	ER'S NAI	ME (First,	Middle, Meiden	Surname)		111-2
H	Edward E. F										<u>litchel</u>			
2	19a. INFORMANT'S NAME (ber, City or Town		Code)	
.	Dolores J.								Hanc		MD 21			
	20a. METHOD OF DISPOSIT 1	n 3 🗆 Remov	rei from State	20b.PLACE	metory or of	her plece)				1		CATION —		
1	21. SKINAFURE OF FUNERA		NSEE	Smith	sburg	Cre	matc	D ADDRES	S OF FAC	2/2/	/98Smit	hsbu	rg, M	ID.
Ē	61) (X X								ne, P.A			
_	Kuch	w		Morris		P	.O.I	30x 3	68 H	lance	ock, M	217	50	
	23. PART I. Enter tha di shock, or h	iseaaes, or ca asrt failure. L	implications that	t caused the de see on each line	eth. Do n	ot enter	the mo	de of dyi	ng, such	as can	diec or reepi	ratory srn	est,	Approximats interval Between
- 1	IMMEDIATE CAUSE (Fir	nei	orașes u											Onsat and Death
	disease or condition	→ a.	Pneumo	onia										13 days
				(OR AS A CONSE	DUENCE OF	ገ:								
8	Sequentially list conditi	lons. b.	COPD											10 yrs.
Ě	if sny, isading to imme- ceuse. Enter UNDERLY	diate	DOE 10	(OR AS A CONSE	JUENCE OF):								
윤	CAUSE (Disease or inju- that initiated events		DUE TO	(OR AS A CONSE	DUENCE OF	า:								
CERTIFICATION	resulting in death) LAS	T .												
빙┃		0.												
EDICAL	PART II. Other eignifice	nt conditions	contributing to	death but not r	esulting i	n the un	derlying	ceuse g	iven in I	Pert i.	24a. WAS AN PERFOR		24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
8										- 1	1 TYES 2	NO		OF DEATH?
														1 YES 2 NO
PHYSICIAN: M	DID TOBACCO U		IBUTE TO CA					UNC	ERTAIN	4 🔲				
ᅙ	25. WAS CASE REFERRED TO EXAMINER?	_	HOSPITAL:	26. PLAC	E OF DEAT	OTHER					_		-	
≥	1 YES 2 NO		1 Inputient 2			4 🗆 Nurs	ing Home	5 X Ra	sidence					
		Pending	28a. DATE OF (Month, D		28b. TIMI INJ	URY	28c. INJI WO	RK?	100	28d. DES	CRIBE HOW II	IJURY OCC	URED	
≽	2 Accident	investigation	26a PLACE O	F INJURY — At ho	me form o	trant facts		ES 2	NO	201 1 00	ATION (Street a	- 1 61		
		Could not be datermined	building,	atc. (Specify)	**************************************	ATBERT, FRICTO	ory, office				or Town, State)	na Number	or Hunei F	loute Number,
<u> </u>	29a, CERTIFIER . A						_							
물	(Check only		AN: To the beat of											come marine manual m
COMPLETED		_	On the basis of e	tamination and/or	Investigatio	n, in my o	pinion, di	ath occur	ed at the t	time, data	end place, and	d dua to the	e cause(a) and menner as stated.
띪	29b. SIGNATURE AND TITLE	OF CHITIFIER	- 70 %	20				29c. LICE	NSE NUM	BER	7	29d. DATE	SIGNED	(Month, Day, Year)
0	30 NAME AND ADDRESS	PEDENTINI	COMPI	111	A AT 4	Date:		V	120	1		- 2	B1	178
	Frank B Th	nomas,					1 0	2.17	LIC	000	nl. 14	4 0	170	
	31. DATE FILED (Month, Day	Venet	20 DECISTRA	DIS CICNATURE	wo T	UIIU.	T O M S	э у	па	псо	ck, M	J. Z	1/5	U
	MAR 04	1998	Julia Da	4dson-Pan	de 00_	3								
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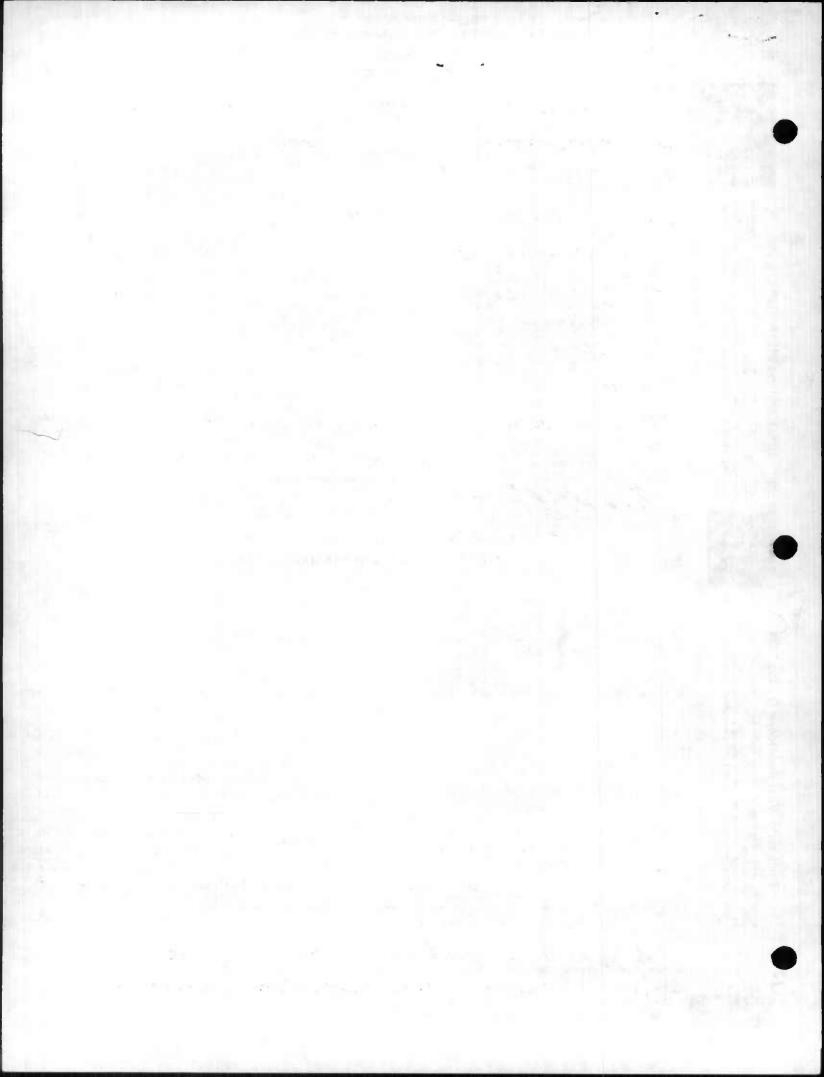
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. AM State of Maryland / Department of Health and Mental Hygiene UNK.98-041 Certificate of Death 3. Time of Death 2. Data of Death 1. Decedant's Nama (First, Middle, Last) Day **Physician** Harris Kasheed FEBRUARY 22,1998 4:10 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner 3700 BLK.WEATHERDSVILLE BALTIMORE RD. 5. Social Security Number If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-20-78 Birthplaca (Stata or Foraign Country) 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 150M 20 F Months Days Hours Min. 19 mD 219-96-1413 Yrs. Director Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examiner must be notified at Baltimore 1 ₽Yes 2 No MD Director 10e. Street and Numbe 10f. Zip Code 10g. Citizan of What Country? 21218 Montpelier U.S.A. 1621 2 should be filed within 72 hours after daath and Mental Hygiene. Is merked other than "natural", or items 23. Funeral 12. Was Dacaden! Ever in U,S. Armed Forces? 1 □ Yas 2 12 No If Yas, Giva Yaar or Datas: 14. Race - American Indian. 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, etc. 1 Danayar Marriad 2 Married Black Baltimore, Maryland 21215-0020 1 Yes 2 Specify: P A 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Schools Public Elementary/Secondery (0-12) Collega (1-4or 5+) Student grade NA 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Wilson Breston Harris To 19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pegas 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other treun DBCB. 21212 Batto. o mo 505 Campbell lane, Braston Harns 20b. Placa of Disposition (Nama of gametary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) mem 21. Signatura of Eunaral Sarvice Licansas 22. Nama and Addrass of Facility Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. Just only one cause on each line. Blunt force head injuries **Physician** and /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Strangulation Examiner Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enlar Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequenca of): physician a Physician/Medical Due to (or as a consequence of) as ISB 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by I 3 Probably 4 Unknown 1 Yes 2 No py 24b. Wara autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy Completed hes Ves 2□ No 17 Yas 2 No Be 25. Wes casa referred to medical 26. Place of Death (Chack only one) Other: 4 Nursing Homa 5 Nesidence 6 Other (Specify) PARK Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 28d. Describe how injury occurred
Struct on head with blant object 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 27. Mannar of Death 28c. Injury at Work? Certification: 5 Panding 1 Natural 1 Yas 2,2 No daath. invastigation and Stranguled with a ligature
281. Location (Street and Number or Rural Route Number, d'sville City or Town, Stete) 3700 block Wetheredsville 2 Accident Found 2-22-98 unknown after death 6 Could not be 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida Unknown - Found in a Park Baltimere City, Maryland

Certifying Phyeician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and menner es steled.

Wether City of the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and menner es steled.

Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the Hospital within 24 hours To the Funeral 29a. Cartifier Medicai (Check only one) 29b. Signeture and titla of certifier 29c. Licensa number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Itam & 3a) (Type, Print) OCME FEBRUARY 23, 1998 Stephen Radentz 111 Penn Street, Baltimore, Maryland 21201 31. Date flied (Month, Day, Year) 32. Registrar's Signatura State MAR 04 1998 Registrar

98-0896-510 Item: 26 Per MD Film G-757 3-4-98RC



of Maryland / Departm	nent of He	alth and	Mental	Hygie
Certific	cate of De	eath		Reg

HIVELY **Physician** /Medical Examiner

FRANKLIN

Funeral Director

with the Mandend r than "natural", or itame 23a or 28a-f show the Modical Examiner must be notified at deeth

permit. Pages 1 and 2 should be filed within 72 hours after to Deperment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or iten any Injury or other traumatic event, the Mod rail Exertine page.

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Division of Vital Records.

Physician /Medical Examiner

he se esn detached the signed by 99 peen page 2 certificate has director.

After this uneral To the Hospital or Attending Pt within 24 hours effer death.

To the Funeral Director: After it completely filled in by the funera

3. Time of Death 2. Data of Death 1. Decedant's Name (First, Middla, Last) Month Franklin Garland Hively 27,1998 FEBRUARY 5:35A.M. 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 7853 ST.CLAIRE LANE NORTH POINT BALTIMORE Co. If Under 1 Year | If Undar 24 Hrs. 8. Data of Birth Jan 25 1946 Birthpleca (Stete or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Hours Months Days Min ₩ 2 F 214-44-1562 52 Yrs. Usual Rasidenca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 1 ☐ Yas 2 No Directo Balto, Co. Dundalk 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? USA 7853 St. Claire Lane 21222 Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Dates: Wes Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 11. Meritel Stetus 1 Nevar Marriad Married White 1 Yas 2 No Spacify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Dacedent's Education (Specify only highest greda complated) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16h Kind of Businass/Industry Elementery/Secondary (0-12) Collage (1-4or 5+) Merchant Seaman Merchant Marine 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fethar's Nema (First, Middle, Last) Be Henry Frank Hively Ethel Lela Hayworth 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 7853 St. Claire Lane, Dundalk, MD 21222 Janice L Hively (wife) 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a, Mathod of Disposition 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata Metro Crematory Feb 28 1998 Catonsville, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensaa 22. Nama end Address of Facility Charlton Funeral Home Dean P Charlton

2007 Eastern Ave, Baltimore, MD 21231

23a. Part1. Enter the disease, or complications thet caused the death. Do not anter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intarval Batween Onsat and Death Immediata Causa (Final disease or condition resulting in death) a Contact Gunshot wound of chest Due to (or es a consequenca of): Examiner Sequentially list conditions, if any, laading to immadiata ceuse. Enter Undarlying Ceuse (Disease or injury that initiated avants rasulting in daath) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings aveilable prior to complation of ceuse of death? 24a. Was an autopsy performed? Completed Inspection 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was cese refarred to medicel axaminer? Be 28. Placa of Daath (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5X Residence 6 ☐ Other (Specify) 1 ¥ Yes 2 □ No Lo 28d. Dascribe how Injury occurred 27 Manner of Deeth 28b. Tima of Injury 28c. Injury at Work? Certification: 28e. Dete of Injury (Month, Day Yaar) 5 Panding 1 Netural 1 Yas 2 No 0410 invastigation 2-27-98 2 Accidant self inflicted gunshol wound 6 ☐ Could not ba datarmined 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 7853 St. Chare lane 3 Sulcida 4 T HomicIda Home Ballimore County, Maryland

1 Certifying Physicien: To the best of my knowladga, daath occurred at tha tima, data and place, end dua to tha cause(s) end mannar as steled. 29a. Certifian Medicai Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred et the time, data and place, end due to the ceuse(s) and manner stated. (Check only 29c. Licansa number 29d. Dete signed (Month, Day, Year) 29b. Signatura and titla of certifiar FEBRUARY 27,1998 O.C.M.E. 30. Nama and addrass of person who completed cause of daath (Itam 29a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95

State

Registrar

Stephen

31. Data filad (Month, Day, Yaar)

5.

MAR 04

Radentz

32. Register Signary

Juna Davidson-Rondell

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Deta of Deeth 1. Decedent's Name (First, Middle, Last) 1998 6:45 AM -rancis Heiro 0. March 02 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth St. Elizabeth's Nursing Home N/A Baltimore If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplece (State or Foraign Country) 5. Sociel Security Number 6. Sax 10 M 2□ F Months Days Yrs. 212-09-4613 83 FEB. 15, 1915 Pennsylvania Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Md. Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5232 DeWitt Road 21227 USA Was Decedent of Hispenic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Building Inspector Baltimore County 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Neme (First, Middle, Last) George W. Heird, Sr. Edith Espey 19e. Informent's Name/Reietlonship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ann C. Heird - wife 5232 DeWitt Rd., Arbutus, Md. 21227 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 3/05/98 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State Elkridge, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Mem. Park 22. Name end Address of Fecility 21. Signature of Funeral Service Licenti Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 23a. Pert1. Enter the diseasa, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on aech line. Approximete Intervel Betwaen Onsat end Deeth Upper gastiontestand bleeding Immediate Cause (Finel disease or condition resulting in death) 1 week lympho/2 Due to (or es a consequence of) Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical **Examiner**

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7 is marked other than "natural", or items 23a or traumatic event, the Madical Examiner must be a

permit. Peges 1 and 2 should be filed within 72 hours efter death. Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

certificete

Director

Funeral

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Examiner physician the

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest Physician/Medicai

24a. Wes en eutopsy

24b. Were eutopsy findings eveilable prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one)

Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 28d. Describe how Injury occurred 28c. Injury et Work?

1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier

5 Panding

invastigation

6 Could not be determined

29c. License number

29d. Data signed (Month, Day, Year)

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Buthwere MP 21227 benson Are aussel 3421 WILLIAM

State Registrar

31. Data filed (Month, Dey, Year) MAR 0 4 1998

25. Wes case referred to medical exeminer?

1 Yes 2 No

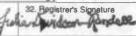
27. Menner of Deeth

1 Neturel

2 Accident

3 Suicide

4 Homicide

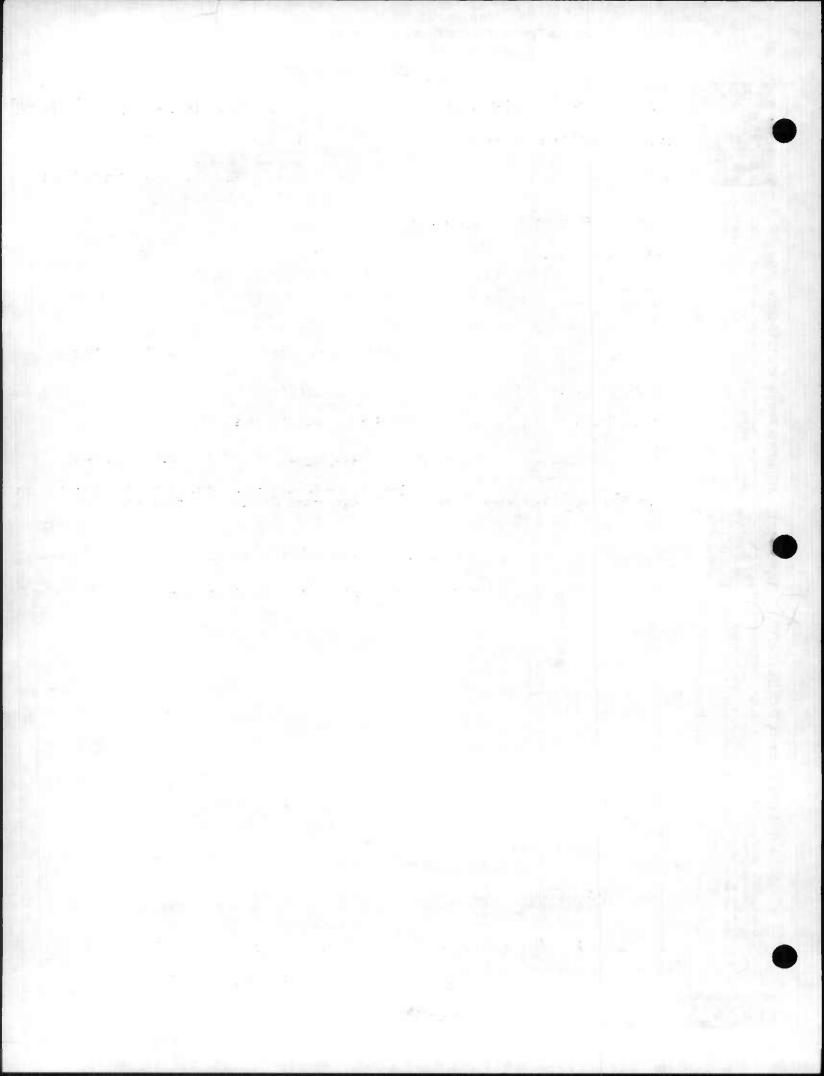


Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

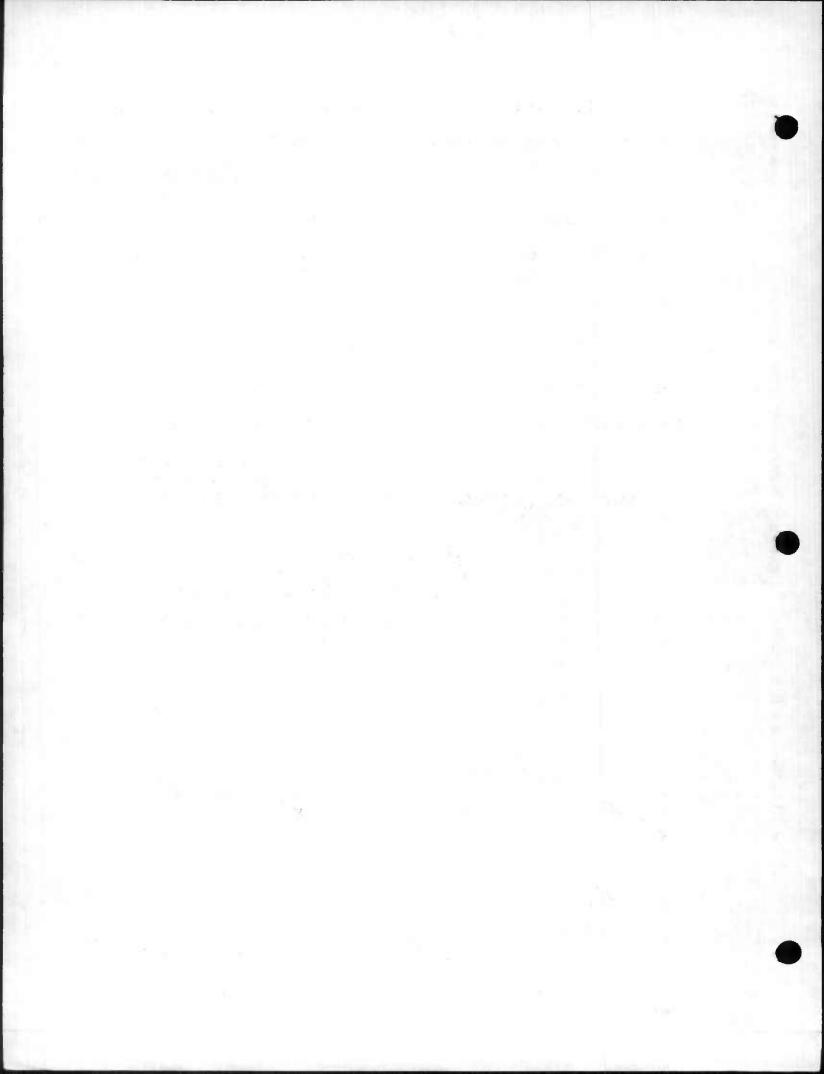
28e. Dete of Injury (Month, Dey Year)



State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death 1. Decedent's Neme (First Middle Last) 3 Time of Death 2. Dete of Deeth Month 02 Holloway **Physician** 07:55 AM helma 26 98 /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** FREDERICK VILLA NURSING CENTER CATONSVILLE BALTIMORE 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys 1 □ M 2 1 F Yrs. Director 212-01-0147 94 JULY 6,1903 MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD HOWARD ELLICOTT CITY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ö 3059 OAK GREEN CIRCLE Nerns 23a 21043 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status filed within 72 hours after 1 □ Never Married 2 □ Married 5 1□ Yes 2□No Baltimore, Maryland 21215-0020 Specify. Specify: þ WHITTE 3 XWidowed 4 ☐ Divorced "neturel", Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) Hygiena. permit. Pages 1 and 2 should be filed w
Department of Heelth and Mental Hygien
Important: If item 27 is marked other thu SECRETARY PAINT COMPANY 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be GEORGE H. KIRBY 2 LULA BLANCHE (SPECK) 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) GEORGE V. MCGOWAN (NEPHEW) 400 QUARTER CREEK DRIVE QUEENSTOWN, MD21658 20b. Pleca of Disposition (Neme of cemetery, cremetory or other placa, 20e. Method of Disposition Date 20c. Location - City or Town, Stele 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) LOUDON PARK CEMETERY 3/2/98 BALTIMORE CITY 22. Name end Address of Fecility WITZKE FUNERAL HOMES, INC. 21. Signeture of Funeral Service Licenses Robert & 1630 EDMONDSON AVE CATONSVILLE, MD 21228 23e. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one eacle on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner The law requires that the death certificete be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enler Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest and physician a Box 68760. Physician/Medical Due to (of as a consequence of): for use as USB Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? á 1 □ Yes 2 □ No 3 Probably 4 Unknown signed to þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? peen paga 2 has this certificata 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital itatior Attending Physician: 25. Wes case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Medical Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Deeth 28e. Dele of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1 Naturel 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospitation Attends within 24 four's after death. To the Funeral Director: A complately diseash by the fo investigation 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide ertifying Phyeicien: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 29a. Certifier dical Exa niner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of o 29c. License number 29d. Dete signed (Month, Dey, Year) completed cause of deeth (nem 23a) (Type, Print) Voverne 10 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State 4 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q

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Funeral Director	5. Sociel Security Numbar 219 10 1444 Usual Rasidance of Decedent	6. Sax 1 Ø M 2 □ F	7. Aga (In yrs. las 72	st birthday) Yrs.	If Undar Months	1 Yaar Days	If Undar a	24 Hrs. 8 Min.	Data of Birth	,19 25		placa (State or Foreign PDAND	
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should be man	19a. Informant's Name/Ralationsh	p (Type, Print)		19b. Maili	ng Addrass	(Street	end Numbe	er or Rural F	Route Number	r, City or Town	State, Zip	Code)	
alth alth	ELIZABETH S. HA	RTGE, WIF	E	140 H	HAVILA	AND	MILL	ROAD,	BROOKE'	VILLE,M	D. 21	0833	
Peges 1 end ent of Healt nt: if item 27 ry or other	20a. Mathod of Disposition 1 ☐ Burial 2 Ø Cramation 4 ☐ Donation 5 ☐ Other (Sp.		Stata	netery, cre	osition (Nam metory or of	thar pla				20c. Location		own, Stata	
permit. Per Departmen Important: any injury pace.	21. Signatura of Funaral Sarvice L	21. Signatura of Funaral Sarvice Licansaa WIRIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882											
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certificate be executed nding physician and use as the burial-transit n/Medical Examiner	Sequantially list conditions, if any, leading to immadiata ceuse. Entar Undarlying Causa (Disaase or Injury that initiated avants rasulting in death) Last	c. 0	Due to (or a	is a consec	wanaa afti	0	U OF				1 1	4	
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requires that the death een signed by the atter hould be deteched for the	Part II. Other significant condition	a contributing to da	ath but not rasuit	ing in tha u	indarlying ca	ausa gh	ven in Part I	l.	23b. Did to	~	ontribute t	to the cause of death?	
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ysicien: The secreticate director, pag	25. Was cesa refarred to medical axaminar?						-	a of Daath (Check only or	ne)			
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Hospi 4 hours Funer tely fill	29a. Cartifiar Certifying (Check only one)	Physician: To the xaminar: On the ba	sis of axaminatio	edge, daat n and/or in	h occurred e	et tha ti	ma, date en opinion, dee	d piece, an	d dua to tha d at tha tima, d	causa(s) and m data and place,	annar es s and dua t	stated. to tha ceusa(s)	
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290. Signature and titla of certifiar

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30 Name and addrass of person who complated ausa of daath (Itam 23a) (Type, Print) DONALD LEWIS HD

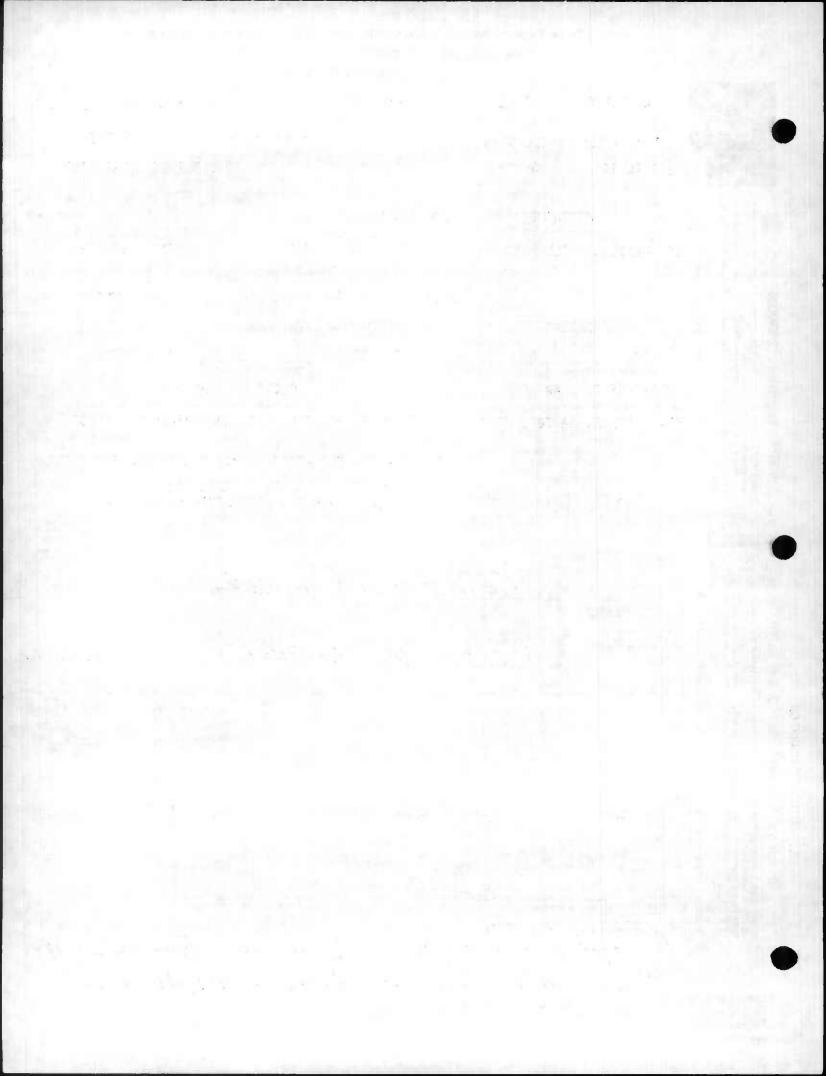
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Registrar

32 Registrar's Signatura

DHMH 16 Rev 6/95

C. WILLIAM HARTGE



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Voer **Physician** 5:35 AM Harry Jones February 1998 28 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Stella Maris at Mercy Hospice Baltimore n/a If Undar 1 Yaar | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **XX** 2□ F 214-32-5517 62 Yrs. Director Sept. 4, 1935 Md. Usual Residence of Decedent tha Marylend 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinal must be notified at 10d. Inside City Limits Md. n/a Baltimore Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citlzen of What Country? 21239 1651 E. Belvedere Avenue USA Apt. 316 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 14. Race - Amaricen Indian, Black, White, etc. Department of Haalth and Montal Hygiena. Important: If Item 27 is marked other than "natural", or heany injury or other trauman. 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: 1 ☐ Yes 2 No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Jones, Harry Little Sisters of Elementary/Secondary (0-12) College (1-4or 5+) Laborer The Poor 8th Grade 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Dryden Jones Pearl 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma C. Jones 1651 E. Belvedere Avenue Apt. 316 Balto., Md. 21239 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXXurial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Head of The Creek U.M.C. March 10 Wicomico, Md. 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licensy 2501 Gwynns Falls PKWY Baltimore, Md. 21216 2501 Gwynns Falls PKWY Balti
23a Part 1. Enter the disease, or complications that course the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Mess Approximate Interval Betw Onset end Death **Physician** /Medical Immediate Cause (Final . Metastatic Hostale disease or condition resulting In death) GYMZ Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 6876 Due to (or as a consequence of): certifica! 88 attending p The law requires that the death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? the th signed by 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, þ 9 24b. Were autopsy findings available prior to completion of ceuse of death? Be Completed 24a. Was an autopsy performed? peen paga 2 1 X Yes this certificata 2 No 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending death. 1 Yes 2 No Investigation 2 Accident Director: J 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) eftar 4 Homicide To the Hospital within 24 hours e To the Funeral C complataly filled Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. Licensa numbar 29d. Date signad (Month, Day, Year) 140480 Dam my March 1, 1998 3 7672 30lain

State Registrar

FERRO, MD 32 Registrar's Signature Windows MAR 0 4 1998

34/10

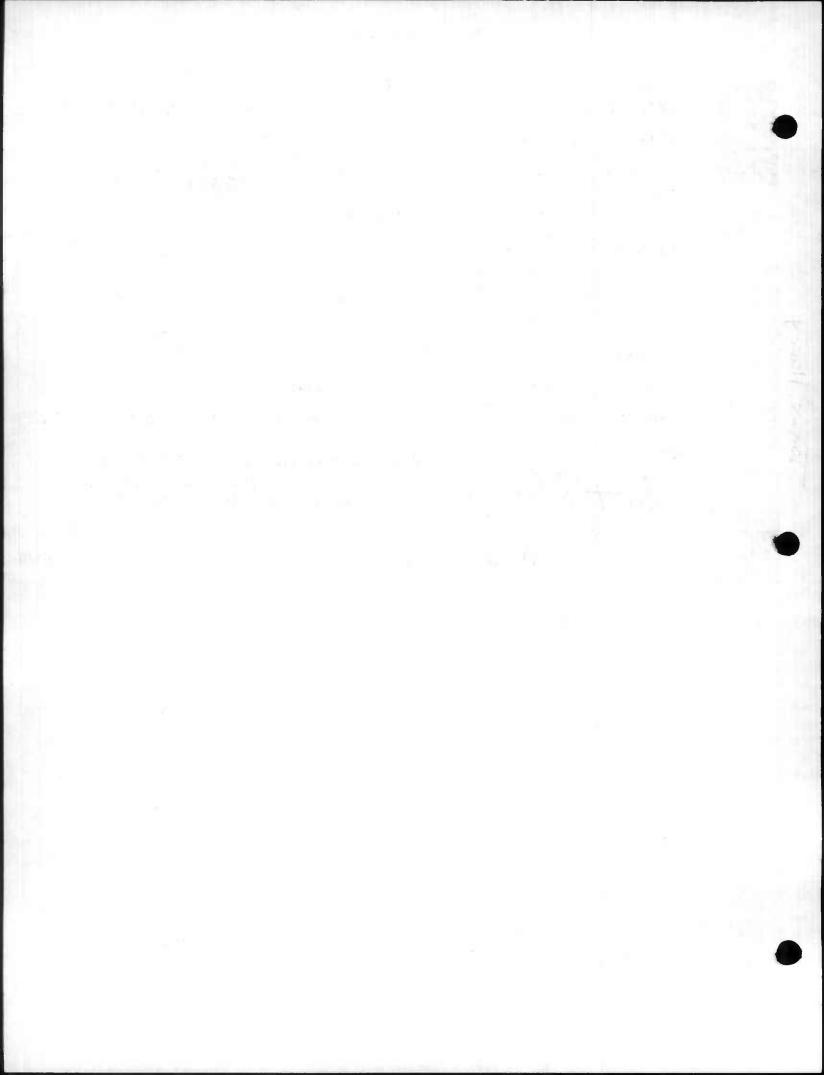
MD

21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANDO

31. Data filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Courth Day **Physician** 2, Ursula 1998 Victoria Kahler March 13:28 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore
If Under 24 Hrs.
Hours Min. Mercy Medical Center N/A If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) **Funeral** Days Months 1□ M 2 F Yrs. 213-34-4448 89 April 12, 1908 Director Maryland Usuel Residence of Decedent with the Meryland r 28a-f show a notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo Maryland N/A Baltimore 10g. Citizan of What Country? 10e. Street end Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health end Meniel Hygiena.
Important: if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. United States 524 North Charles Street - Apt. 1110 21201 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: ò White 3 ₩idowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) <u>Licenced Practical Nurse</u> Medical 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumeme) Peter Zelinskas Ursula Solder 19e. Informant's Neme/Reletionship (Type, Pnnt) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 939 Horners Lane Baltimore, Maryland 21205 James E. Kahler / Son 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Steta 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 3/5/98 Baltimore City, Maryland Most Holy Redeemer Cemetery the Licensee Timothy S. Harman 22. Neme and Address of Fecility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Pert1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such es cardiec or respiretory errest, shock, or haart failure. List/only one cause on each line. Approximata Intervel Between Onsat end Death **Physician** Immediete Ceuse (Final disease or condition rasulting in death) /Medical SEPSIS 6 HOURS **Examiner** Due to (or es e consaquance of): Examiner PERFORATED DIVERTICULITIS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initieted events resulting in death) Lest Due to (or es e consequença of): Box 68760 Physician/Medical Due to (or es e consequenca of): usa as t 23b. Did tobacco use contribute to the cause of death? datached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 1 No 3 Probably 4 Unknown Division of Vital Records, by 24e. Was en eutopsy performed? 24b. Wara autopsy findings eveilable prior to Completed completion of cause of deeth? pega 2 s certificate has 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yas 2 No Be 26. Placa of Death (Check only one) To Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Residenca 8 ☐ Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funerel 27. Menner of Deeth 28a. Data of Injury (Month, Dey Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury et Work? Certification: After 5 Pending Investigation 1 DNaturet efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 6 4 Homicide 8 .5 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the Hosp within 24 hou To the Fune completely fi edical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of pertilled 29c. License number

State Registrar Ira J.

31. Dete filed (Month, Day, Year)

333 St. Paul Place 1-E Baltimore, Maryland
22 Registrar's Signetura

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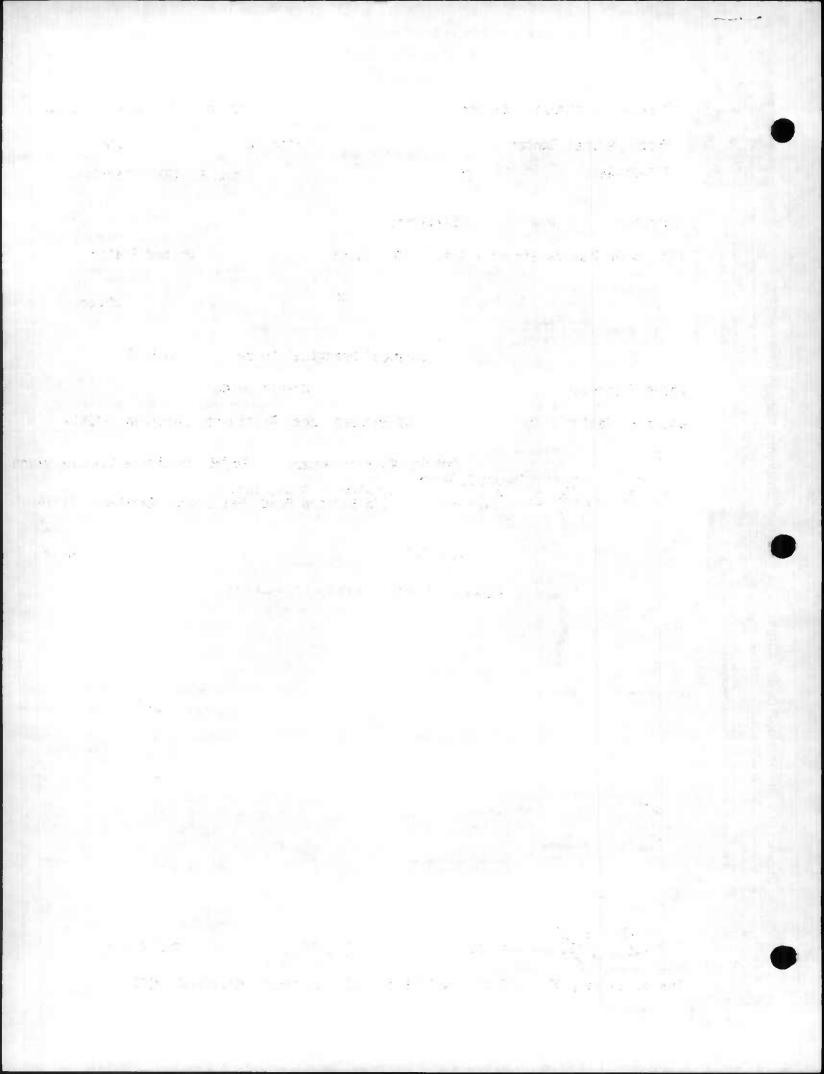
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Dune mo

30. Name end eddress of person who complated cause of death (Item 23a) (Type, Print)

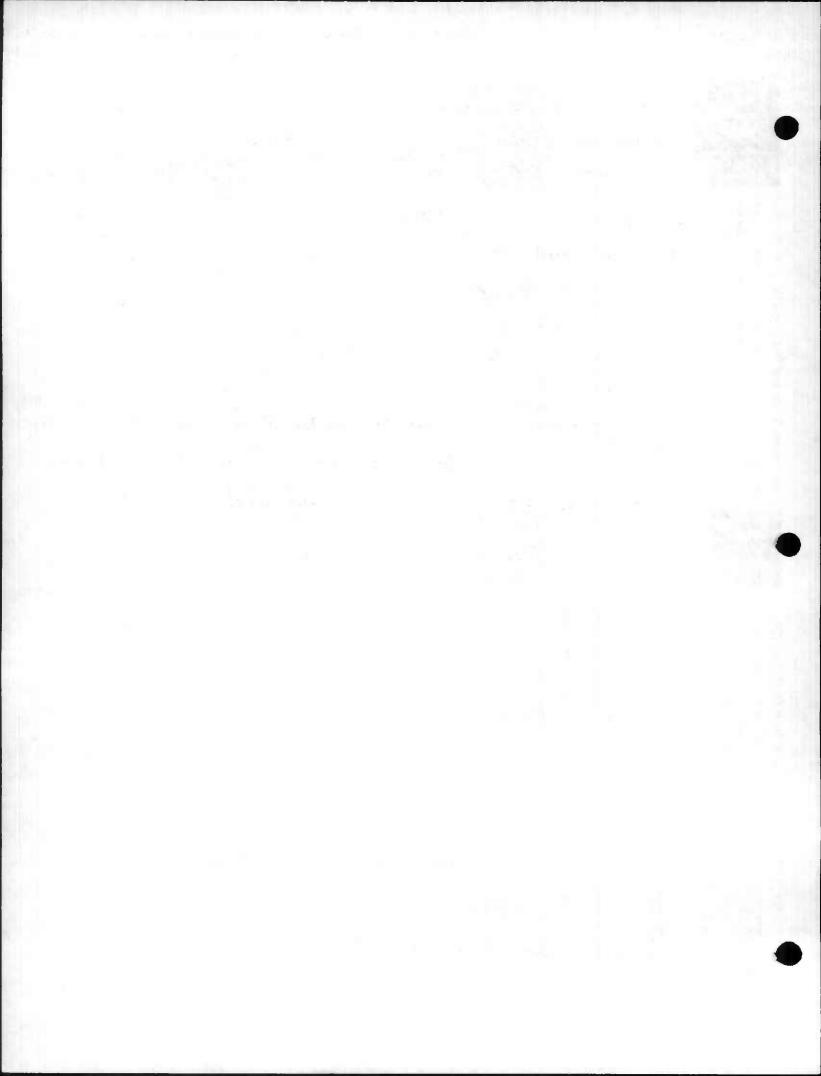
Levine, MD

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State of Maryland / Department of Health and Mental Hygiene

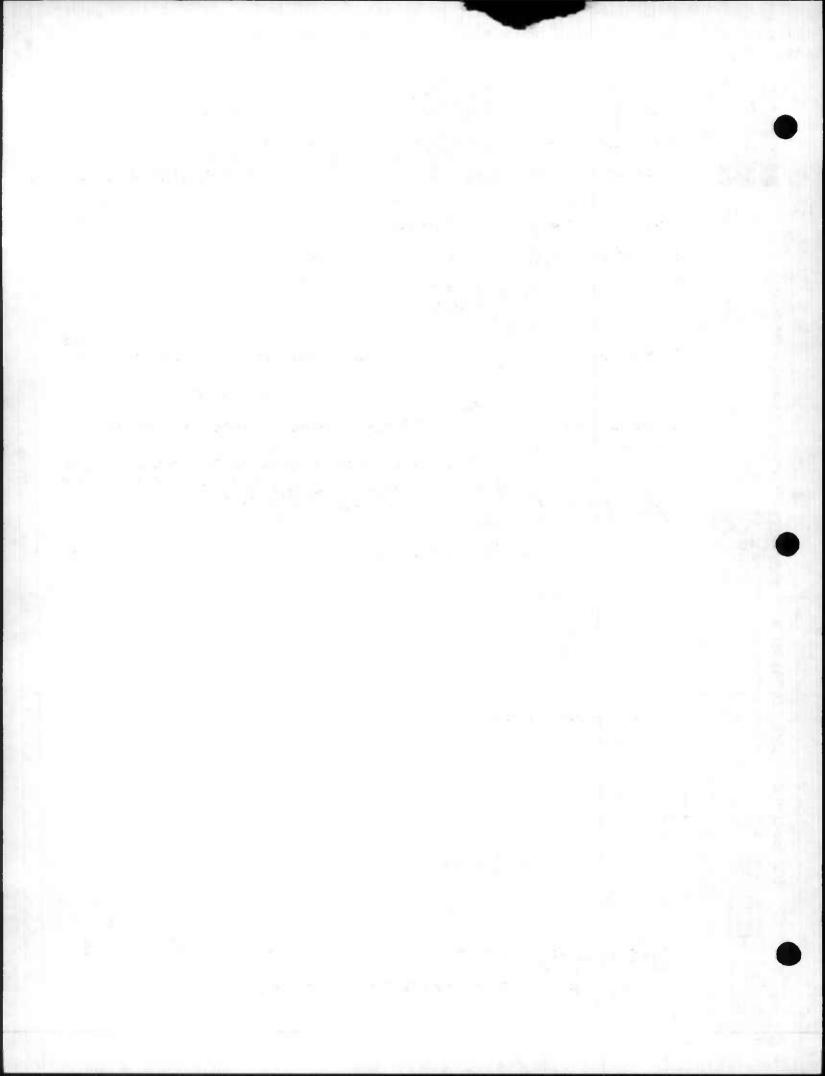
		Certificate of Death	Reg. No.	000//			
Physician	1. Decedent's Neme (First, Middle, Last)		2. Dete of Deeth Month Dey Yeer	3. Time of Death			
/Medical	Catherine F. Katenkamp		February 28 1998	4:00 Am			
Examiner	4e. Facility Neme (If not institution, give street and number)	4b. City, Town, or Loc		eth			
	Keswick Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. lest I	Baltim birthdey) If Under 1 Year If Under 24 Hrs.					
Funeral Director	220 20 2840 1 M 20 F 59	Yrs. Months Deys Hours Min.	Month, Dey, Year) July 29 1908	rthplace (State or Foreig			
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\$ P	Marriand Bai	Itimore	₩ Yes				
or 28a-f s be notine	10e Street and Number	10f. Zip Code	10g. Citizen of Whet Country?				
3a o	700 W. 40th Street	21211	US	A			
thyliena. ther than "natural", or items 23a or 23a-f show but, the Medical Examinat must be notified at a Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuben, Mexican, Puerto I 1 ☐ Yes 2 ☑ No Specify:					
natural', edical Exa leted by	15. Decedent's Education 16	Sa. Decedent's Usuei Occupation	16b Kind of Business				
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and Mantal I is marked of reumatic eve	1 ·	9b. Meiling Address (Street end Number or Rure		Zip Code)			
t Health and Mantal Hygiena. Item 27 is marked other than other treumetic event, tra Mantal To Be Compl		OL Baltimore Ave. Ste.					
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Department comportant: If any injury or once.	21. Signeture d Funeral Service Licensee	22. Neme end Address of Fecility EVANS C 2325 York	hapel of Chimes Rd. Timonium Md	21093			
	23a. Part1. Enfer the disease, or complications that caused the death. Do shock, or heart feilure. List only one cause on each line.		r respiretory errest,	Approximete Intervel Between			
n and ial-transit mand Examiner	Cetellio - n	e consequence of): Outuber discuse e consequence of):	ar accident	unkur			
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2 should			24a. Wes en eutopsy performed?	Were eutopsy tindings avelleble prior to completion of cause of death?			
page Com			1 Yes 2 1 No	1 Yes 2 No			
s certificate director, pa	25. Wes cese referred to produce examiner?	26. Plece of Death	(Check only one)				
0 0	Hospitel:	Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Spe	ecify)			
octor: Atter the by the funeral	27. Manne of Deeth 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident Investigation 28e. Dete of injury (Month, Dey Year)	28c. Injury et Work? M 1 Yes 2 No	ury et 28d. Describe how Injury occurred ork?				
od in Cert	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street end Number or Fi City or Town, Stete)	Rural Route Number,			
in 24 hours he Funeral pletely filled edical Ce	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge of the basis of examination early medical Examiner: On the basis of examination early menner steted.	ge, deeth occurred et the time, dete end plece, e and/or Investigetion, in my opinion, death occurre	nd due to the ceuse(s) end menner a od et the time, date end plece, end du	s steted. e to the ceuse(s)			
within 2 To the comple	29b. Signature end title of certifier M. Habelle Tax Jegn M	29c. License number D/3657	29d. Date signed (Mon				
8	30. Name end eddress of person who completed ceuse of death (Item 23e) REGR, KESW1C.	D D13657 D1700 W 40 HS+	Balxo more, 1	7d 21211			
State	31. Date filed (Month, Day, Year)						



State of Maryland / Department of Health and Mental Hygiene

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show	7	10e. Stete 10b. County		10c. City, Town o						10	0d. Inside City Lim	
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feath res 23	Funeral	1705 Chilton Str	12. Was Decedent	Ever in U.S.	3. Was Dec		218 Hispenic Origin? (Specify Yes or No-	US 14. Rad	A ce - Americ	an Indien.	
n 72 hours after death with the Maryland "hatural", or itams 23a or 28a-f show edical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced		No reo '54		ecify Cub 2) No		Specify Yes or No- rto Ricen, etc.)	Specif.	ck, White, o	etc.	
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1 end Health em 27		Bertha L. Kenlaw					Street	Baltim	ore, MD	212	18	
Peges 1 e nent of Hee nt: If Item iry or othe		20a. Method of Disposition 1			cremetory of	other ple	•	Date Mar 2nd	20c. Location			
permit. Peges Department of Important: If II any Injury or once.		21. Signeture of Funeral Service Licen	6 4		22. Name 2501	and Addre	ess of Fecility ns Falls	Nutter Fi				
		23e. Part T. Enter the disease, or companies shock, or heart tailure. List only		d the death. Do not	Balti enter the m			216 ac or respiretory en	rest.		Approximete	
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Attending I r death. sctor: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2 □ No	OR Leasting (C	Name of Advanced Advanced	h 0	I Day to More bear	
i Sit o	Certification:	4 Homicide determined	28e. Place of tnjury - At home, farm, street, tectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number building, etc. (Specify)								i Houte Number,	
To the Hospital or Att within 24 hours effer of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) Cartifying Physics Medical Exempton	valcian: To the best linar: On the bests o end manner st	f exemination end/o	eeth occurre r Investigatio	d et the ti	me, dete end plac opinion, death occ	e, end due to the durred et the time, d	ceuse(s) end m dete end place,	enner es st end due to	eted. the ceuse(s)	
withii To th	×	29b. Signature and title of certifier			2	-	se number	- 1	29d. Date signe			
		1 Teles				1)	41128		2-2	7 - 0	78	
a. i. i		30. Name and address of person who	completed ceuse of o	leeth (Item 23a) (Ty	pe, Print)							
UT		Richard Zane	600 No	orth Wolfe	Stre	et B	altimore	, Md. 212	205			
		31. Date filed (Month, Bay, Year)	The section	er's Signature								

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 27, 1998 5:30 p.m Josephine E. Kreller 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death 626 S. ELLWOOD AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1□M 2X F Months Yrs. JUNE 21, 1916 217-05-8152 81 MARYLAND Usual Residence of Decedent 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits Y Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 626 S. ELLWOOD AVENUE 21224 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indien Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) FREDERICK BOLTIES GENEVIEVE SADLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE TAYLOR, SR. 234 E. 8th AVENUE, NORTH WILDWOOD, N.J. 08260 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremetion 3 Removal from State 4 □ Donetion 5 □ Other (Specify) MOST HOLY REDEEMER CEM. 3/3/98 BALTIMORE, MD. 21. Signature of Funeral Service Licenses LTILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING ST., BALTIMORE, MD. 21224 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Less Lung Due to (or es a consequence of) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Chronic Obstructive 24b. Were autopsy findings evelleble prior to complation of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1☐ Yes 2☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

BAGIMONE MO 21224

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumstic syent, the Med cal Examiner maint be notified as

72 hours efter

filed within 7 Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oths any Injury or other traumatic avent, pages.

Examiner physician end the burial-transit Physician/Medical detached signed by ti Completed by has Be 10

Certification:

edical

The law requires that the death certificate be assecuted Box 68760. funeral director, this After 2

Division of Vital Records, P.O. or Attending Physician: efter death.

Director: To the Hospital owithin 24 Hours el

Registrar

31. Date filed (Month, Day, Year)

27. Manner of Death

1- Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

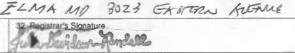
mu.

3 Suicide

29a. Certifier

5 Pending Investigation

6 ☐ Could not be determined



28a. Date of Injury (Month, Day Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

28b. Time of

MO

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

tactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

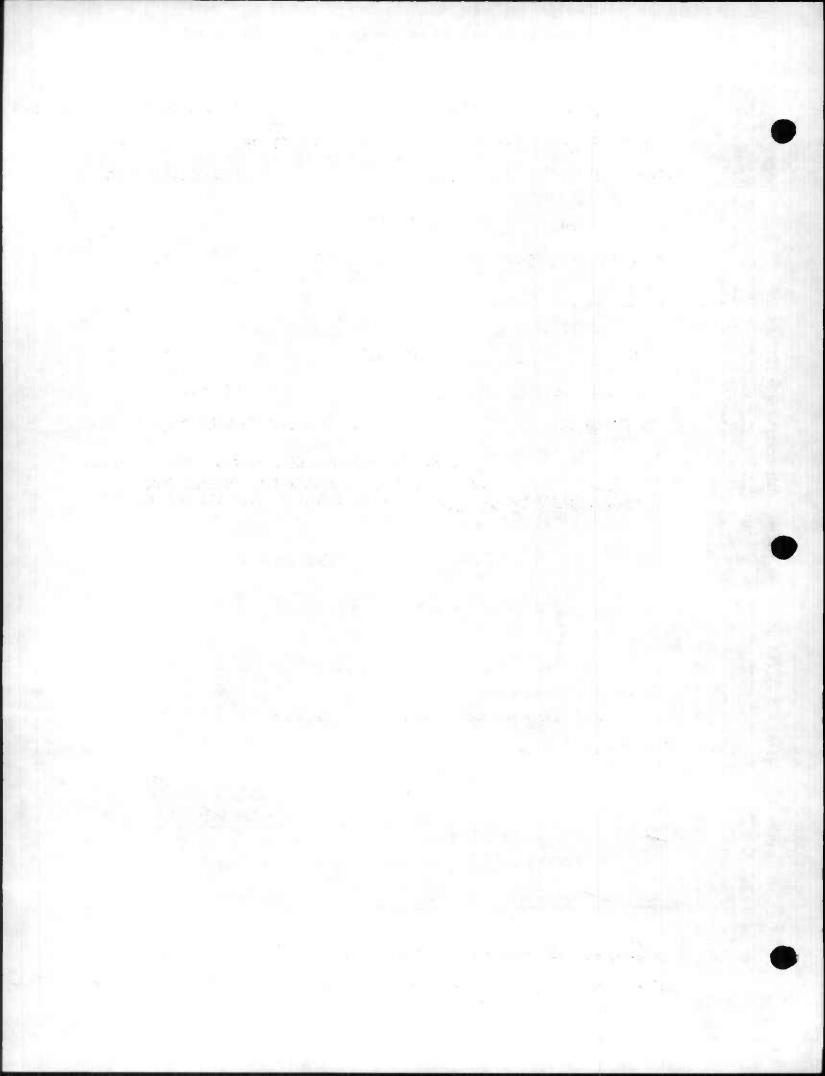
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. License number

1 Yes 2 No

15537

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 1 Item: 24a per M.D G-757 3/3/98 reb Certificate of Death

1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Heron Kuropetva Marion Kuropatva 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth UNIVERSITY of Ne-Yland Nudicel System Boltswick BeltiNSC CIT 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 8. Dete of Birth (Month, Day, Ye July 16, 9. Birthplece (State or Foreign Country) unknown Yeer) 1925 199-16-9299 1 M 2 □ F Yrs. Usual Residence of Decedent 10c. City, Town or Location Baltimore 22 South Broadway 10b. County 10d. Inside City Limits 1X Yes 2 No Baltimore City Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? South Broadway 21231 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? unknown 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Raca - American Indien, Bleck, White, etc. 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) unknown unknown

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

Dete

²² Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street

20c. Location - City or Town, Stete

items 23a or 28a-f shortiner intermedial Funeral permit. Peges 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other treumstic event, the present of the page. þ Completed Be

Physician

/Medical

Examiner

10a State

19e. Informent's Name/Reletionship (Type, Print)

31. Date filed (Month, Day, Yeer)

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □Other (Specify) in state 21. Signature of Funeral Service Licensee, Director

unknown

20e. Method of Disposition

Funeral

Director

28a-f show

Director

the Maryland

Physician /Medicai Examiner

The law requires that the death certificate be executed

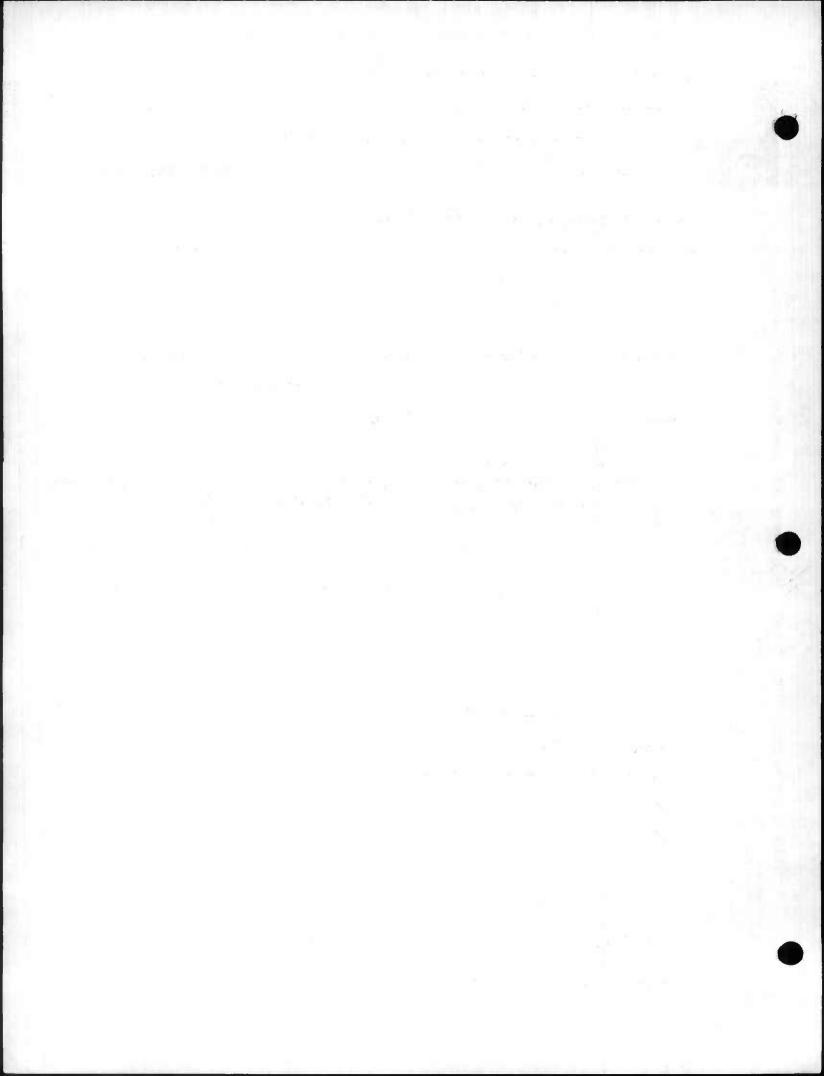
and the signed by Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, p Medical Certification To the Hospital within 24 hours a To the Funeral Completely filled

Division of Vital Records, P.O. Box 68760,

23a. Patt 1. Enter the disease, or compleshock, or heart feilure. List only or	ications that caused the dea			, Maryla g, such es cardie				pproximete		
shops, of heart lendre. List only of	ne ceuse on eech line.							ntervel Between Inset end Deeth		
Immediate Cause (Final disease or condition	Pertin	c Stroke					7	2 hours		
resulting in death)	Due to (or es e consequenca of	f):			_				
	Congest	ve heert	- te	1010 -	Witro	1 11901	gitet			
Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying	Due to (or es e consequenca of):									
cause. Enter Underlying Ceuse (Disease or Injury thet initiated events	Due to (c	-								
resulting in death) Lest	Duo to (t	or es e consequenca en	,.							
	d		-							
Pert II. Other significant conditions cor	ntributing to death but not res	sulting in the underlying	ceuse giv	en in Pert I.	23b. D	ld tobacco use co	ntribute to ti	he cause of death?		
Chronic rivel	failure				1	□ Yes 2□ No	3 Probe	bly 4 Unknow		
LYPERTLYFUID		4			24a. W	es en eutopsy informed?	eveile	autopsy findings able prior to detion of cause ath?		
Chronic Otriel	f. bulleti	01			1	□Yes 21XNo	101	res 2□ No		
25. Was case referred to medical execution?				26. Plece of De						
1 Ø Yes 2 □ No	lospital: 1 Inpatient 2	ER/Outpetient 3□ D	OOA Oth	er: 4□ Nursing I	Home 5□Re	esidenca 6 DOth	er (Specify)			
27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injun Worl	et		28d. Describe how Injury occurred				
3 ☐ Suicide 6 ☐ Could not be determined						28f. Location (Street end Number or Rurel Route Number, City or Town, State)				
29a. Certifier 1 ☐ Cartifying Phyc (Check only one) 2 ☐ Medical Exami	eician: To the best of my knowner: On the basis of examine end menner steted.	owledge, death occurre- ation end/or investigation	d et the tim on, in my op	e, dete end plec linion, deeth occ	e, end due to the urred et the tim	ne ceuse(s) end me e, date end plece,	enner es stet end due to th	ed. ne ceuse(s)		
29b. Signeture end title of cartifier		2	9c. License	number		29d. Date signe	d (Month, De	ly, Yeer)		
+ 4 a M			P 11	747		2191	195			
30. Name and address of person who co	ompleted cause of deeth (Item	m 23e) (Type, Print) 0834 N C	eluci	+ 5+	UNIT	4 Bel	tivo	CND		

unknown 20b. Plece of Disposition (Name of cametery, cremetory or other piece)

State Registrar 92 Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per M.D G-757 Certificate of Death Items: 23 part I,II 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** TWICH 910A FEBRUARY 1998 /Medical 4e. Feclity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTO MIRSING RANKFORN DRIEN CENTER 5. Sociel Security Number 6. Sex 1⊠M 2□ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplece (State or Foreign Country) Days Hours 226-24-825 Director Usuei Residence of Decedent the Marviand 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at NA Director 1 Yes 2 No Ma Baltimore 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? ò 3815 Howerton Herns 23a 21229 S.H death Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece the Medical Exposition filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1□ Yes 2□ No Black by Specify: 3 Widowed 4 Divorced Completed 18e. Dacedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Telephone company nd Mentel Hygiene. merked other than Elamantary/Secondary (0-12) College (1-4or 5+) Stock Room loth grade AHEndant 17. Father's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 Leftwich YOS eu 2 rula Ihornton 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health and Important: If Item 27 Is m any Injury or other traum since. Balty, Md 3815 Lettwich-wife ornella lowerton oad 21229 20b. Plece of Disposition (Neme of cemetery, cremetory or other place 20e. Method of Disposition Date 20c. Locelion - City or Town, Slete 1 Ø Burial 2 ☐ Cremation 3 ☐ Removel from State 2-20-98 Uwings Mills Garrison 4 Donalion 5 Other (Specify) Funeral Service Licensee -F.H West 4300 Balto, nd 21215 Wabash Avenue ent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, lock, or heart failure. List only one causa on aach line. Approximate tntervel Betwo **Physician** /Medical ASCVD Immedieta Cause (Finel weeks disease or condition resulting in deeth) Examiner Dua to (or es e consequence of) Examiner The law requires that the death certificate be executed bunial-trans Sequantially list conditions, if eny, leeding to Immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medical the Due to (or es a consequence of) for use as Pert II. Other significent conditions contributing to death but not resulting in the undarlying cause given in Pert I. detached 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Renal Failure Records, Completed by 90 page 2 should 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? certificate has been 1□ Yes 2□No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Wes cese raferred to medical exeminar? Be 26. Piece of Deeth (Check only one) Othar: 4 Nursing Home 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 5 ☐ Residence 6 ☐ Other (Specify) this 27. Menner of Daath 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending Investigation 1 HNaturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homicide Medicai 29a. Certifier Certifying Physician. To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) and menner es steted. (Check only one) in the basis of examinetion and/or investigetion, in my opinion, deeth occurred et tha time, date end piece, and due to the ceuse(s) and manner stated. 29b. Signeture and title of cartifian 29c. License number 29d. Date signed (Month, Day, Year)

pleted cause of deeth (Item 23a) (Type, Print)

who David

32. Registrar's Signature

M.D.

RKi

+1

State

Registrar

Marie

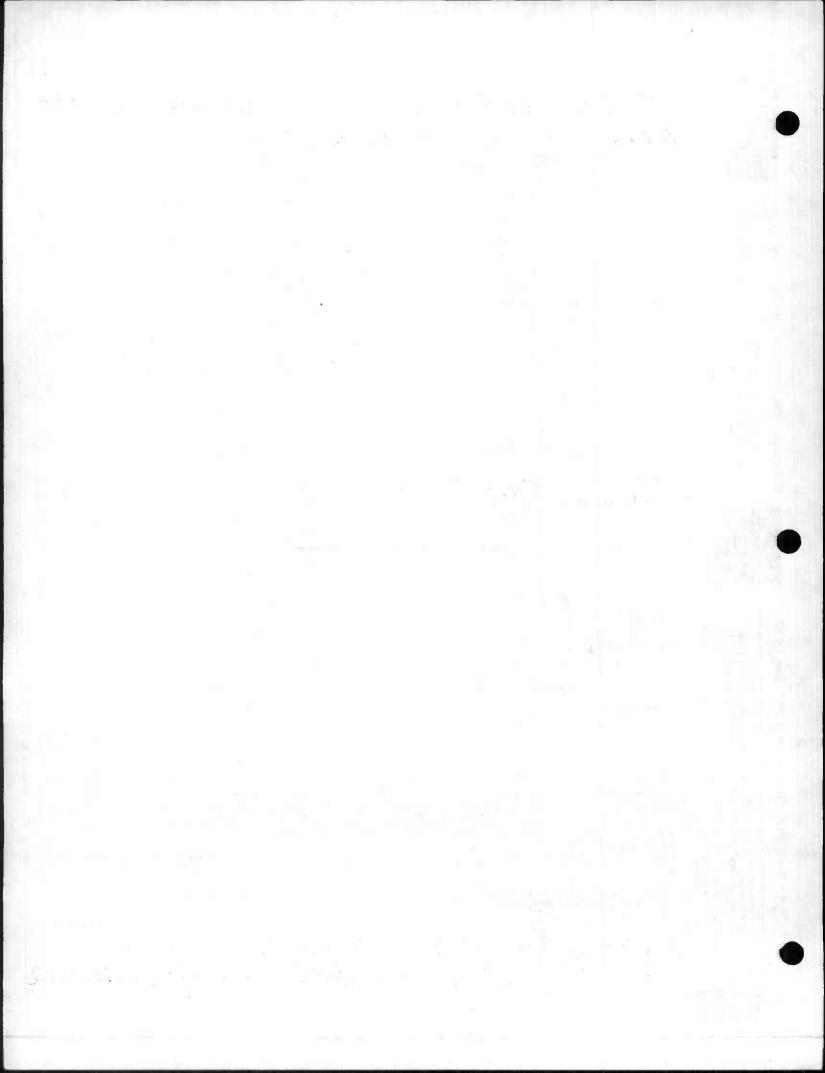
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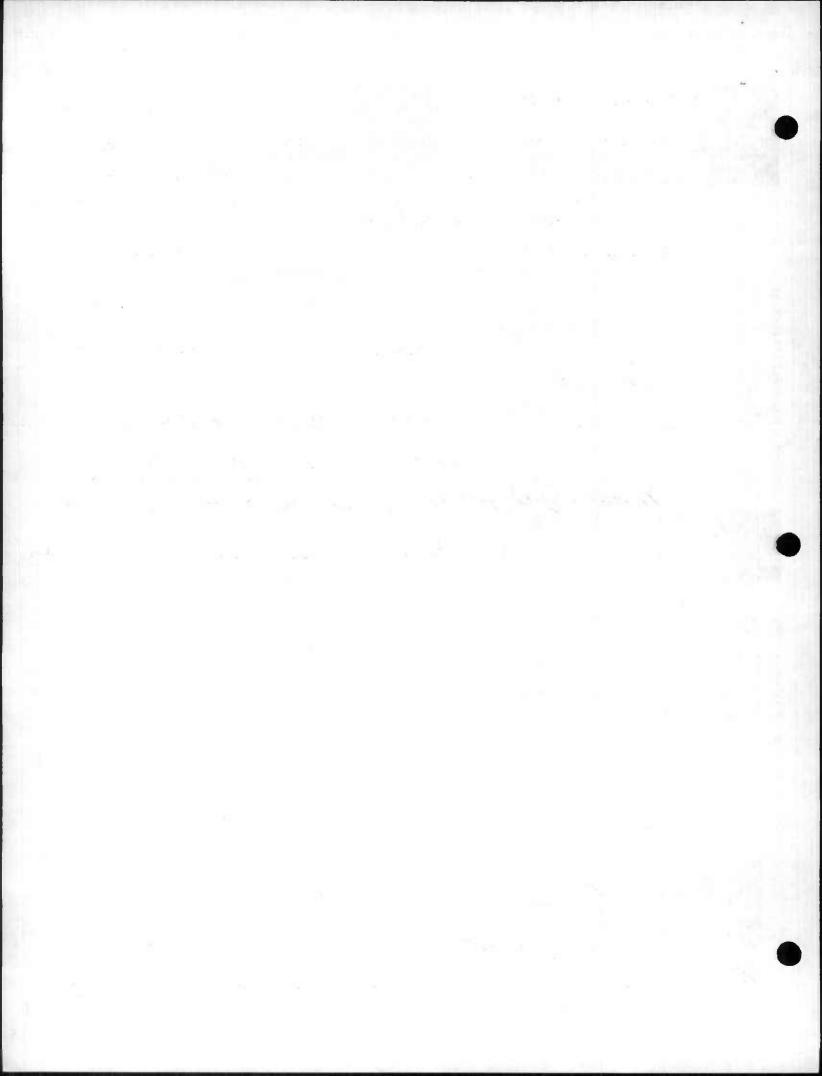
30. Name end eddress of perso

31. Date filed (Month, Day, Yeer)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Name (First, Middle	o, Last)						2. Date of De Month		Veet	3. Time of Dea
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r 28a-f show	ctor	MD Balti	more	Sparks	s/Glend	coe						1 ☐ Yes 2▼
ms 23a or 28a-1 show	Funeral Director	10e. Street and Number 411 Piney Hill	Road		10f	Zip Code 21152				10g. Citizen o		untry?
or He	by Funer	11. Marital Status 1 □ Never Married 2 1 Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces ed 1 Tyes 2 Tif Yes, Give X Year or Detes:	? LNo		ecedent of h specify Cub es 2 No		gin? (Spec , Puerto R	ify Yes or No ican, etc.)	Spec	leck, White	ricen Indian, e, etc. iite
n 'natural', ledical Exz	Completed by	15. Decedent (Specify only highes	t grede completed)	16e	Decedent's l (Give kind o life. DO NO	Usual Occup f work done OT use retire	pation duning most	of working	9	16b. Kind of	Business/l	ndustry
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t of Health and Mental Hygiene. If item 27 Is marked other than or other traumatic event, tra M.	To Be	17. Father's Name (First, Middle, I Gregory Lopos					Irer		riisi, Middle,	Melden Sume	eme)	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** March 2, 1998 ADELAIDE EVE LAW 2:20P /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** St. Agnes Nursing and Rehabilitation Center Ellicott City Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Months Deys 1□ M 2 Yrs 87 December 18, 1910 219-58-5757 Maryland Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 7 is marked other than "natural", or items 23a or traumstic event, the Medical Examinations must be 635 Piccadilly Road 21204 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Haelth and Mental Hygiena. Important: If them 27 is marked other than "natural", or thema 23s any Injury or other traumatic event, the Mad Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes # ANNo If Yes, Give Year or Detes: 14. Rece - American Indien Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕅 No Specify: White py XX Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Joseph Rawlins Martin Elizabeth Donnick 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William R. Law 635 Piccadilly Road Towson, Maryland 21204 Son 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Suriel 2 Cremetion 3 Removel from State Donetion 5 Other (Specify) Dulaney Valley Mem. Gar. 3/4/98 Lutherville, Maryland ature of Funerel Service Louise 22. Name end Address of Fecility Mitchell-Wiedefeld Home Inc 6500 York Road Baltimore, Maryland 21212 wakes 23e. Pert1. Enter the diseese, of shock, or heart feilure. Line aused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** /Medical Immediate Cause (Final END STAGE AdvANCED A/Zheimer's Dementin diseese or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown PREVIOUS CEREBROUASCULAR AccideNTS þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was en eutopsy CORONARY HEART disease 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, and due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end menner stated. edicai 29a. Certifie within 24 hor To the Fune completely fi (Check only one)

Registrar

31. Dete flied (Month, Day, Year) MAR 0 4 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

M. MACHIRAN.

29b. Signature and title of certifier

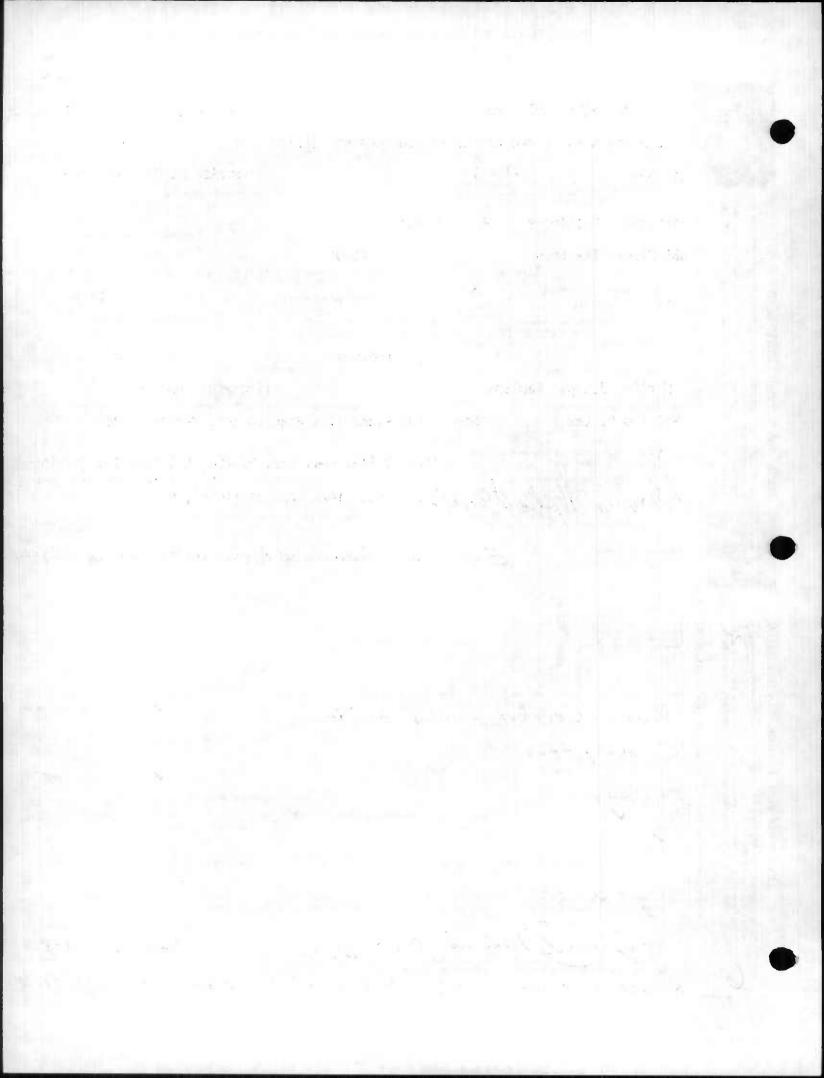
NORBERTO

M.D. 32. Registrer's Signeture ruh , Savidson-Randa 192 29c. License number

29d. Date signed (Month, Day, Year)

March, 2,

720 C MAIDEN CHOICE LANE BALLO. MD. 21228

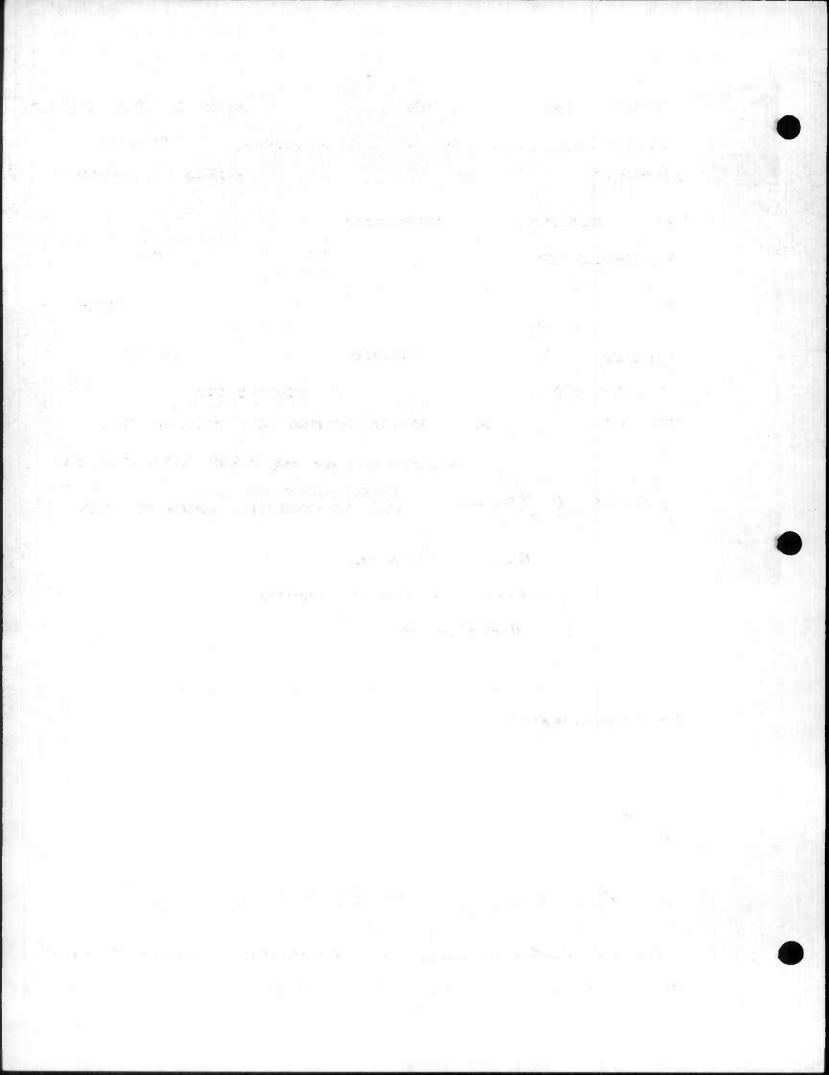


					Cer	tificate of	Death		Reg. No.	8 (16684
Physicia /Medica		1. Decedent's Neme (First, Middle, Last HILDA CAA	iders					2. Dete of D Month	Dey	Yeer	3. Time of Deeth
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Funeral Director		Copper Ric 5. Social Security Number 6. Se 213-40-0577		Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Deys	If Under 24	Ain. (Month, D	rth ey, Year)	9. Birthpl	lece (Stete or Foreign
		Usuel Residence of Decedent						sept.	27,190	Z Ma	aryland
show ad at	ō	MD 10b. County Carro	ll Cour		ty, Town or Loc	ation esville				10	0d. Inside City Limits 1 ☐ Yes 2 💢 No
r 28a	Director	10e. Street end Number	LI COU	197	Булс	10f. Zip Code			10g. Citizen of V	Whet Coun	
23a o		710 (Obrecht	Roa	d		21784		USA	A	
thygiena. ther than "natural", or items 23a or 28a-f show ent, the Medical Exampler must be notified at	by Funeral	11. Meritel Stafus 1 □ Never Married 2 □ Married 3 □ Vidowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Yeer or Date	es? δo		Vas Decedent of I Yes, specify Cub ☐ Yes 2 No	Hispanic Origin en, Mexican, Pi Specify:	? (Specify Yes or Nuerto Rican, etc.)	o- 14. Rec Bled Specify	e - America k, White, o	
"natural",	ted	15. Decedent's Edu	cation	es:	16e. Deced	ent's Usuel Occup	petion		16b. Kind of Bu	usiness/ind	lustry
Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natur any injury or other traumatic event, in a Medical once.	Completed	(Specify only highest grad	e completed) College (1-4	or 5+)	(Give k life. D	rind of work done O NOT use retire Teache	duning most of d)	working		duca	
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Department of Health Important: If Item 27 is any injury or other truouce.		20e. Method of Disposition 1 ☐ Burial ② Cremetion 3 ☐ F		ate	Plece of Dispos cemetery, crem	ition (Neme of setory or other pla	се)	Date	20c. Location -	City or To	wn, Stete
Department Important: I any injury o once.		4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licans		Gr				3/6/98			, MD
Departr Importa any inju		Dobr D. Mix	thell-	I				feld Ho			L2
physicians the burn	Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Lest	b	Due to (d	or es e consequentes	uence of):	erry Ce	uer Me	τ\$		
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s efter death.	Certification:	3 Suicide 6 Could not be determined	28e. Place of building.	Injury - At h , etc. (Special	ome, farm, stre	et, factory, office		28f. Location City or To	(Street end Numb own, Stete)	er or Rura	l Route Number,
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State of Maryland / Department of Health and Mental Hygiene

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/Medi		BETTIE	WEE	3B	LAN	E			MARCH	3 1	998	9:20 A.I
Examir		4a. Fecility Nema (If not i	institution, giva	street end number)				4b. City, Town, or	Location of Death	4c. County	of Death	
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uneral irector		5. Social Security Number 220–07–460' Usuel Residence of Dece	7 18	□M 2120 F	(In yrs. last bir	Yrs.	ler 1 Yaar s Deys	If Undar 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey 4/19/1	Year)		lece (State or Forei try) YLAND
r 28a-f ahow		10a. State 10b.	. County	1	10c. City, Town	n or Location					11	0d. Inside City Limi
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	era	207 CONEWO	OOD ROA	D 12. Was Decedent Ev	er in IIS	13 Was Dec		136 dispanio Origina (S	nacihi Vac or No-	USA 14 Bac	A - Americ	an Indian
'natural', or itams oldai Examiner m	by	1 Navar Married 2		Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				dispanic Origin? (S an, Mexican, Puart Specify:	o Rican, etc.)		ok, White, o	
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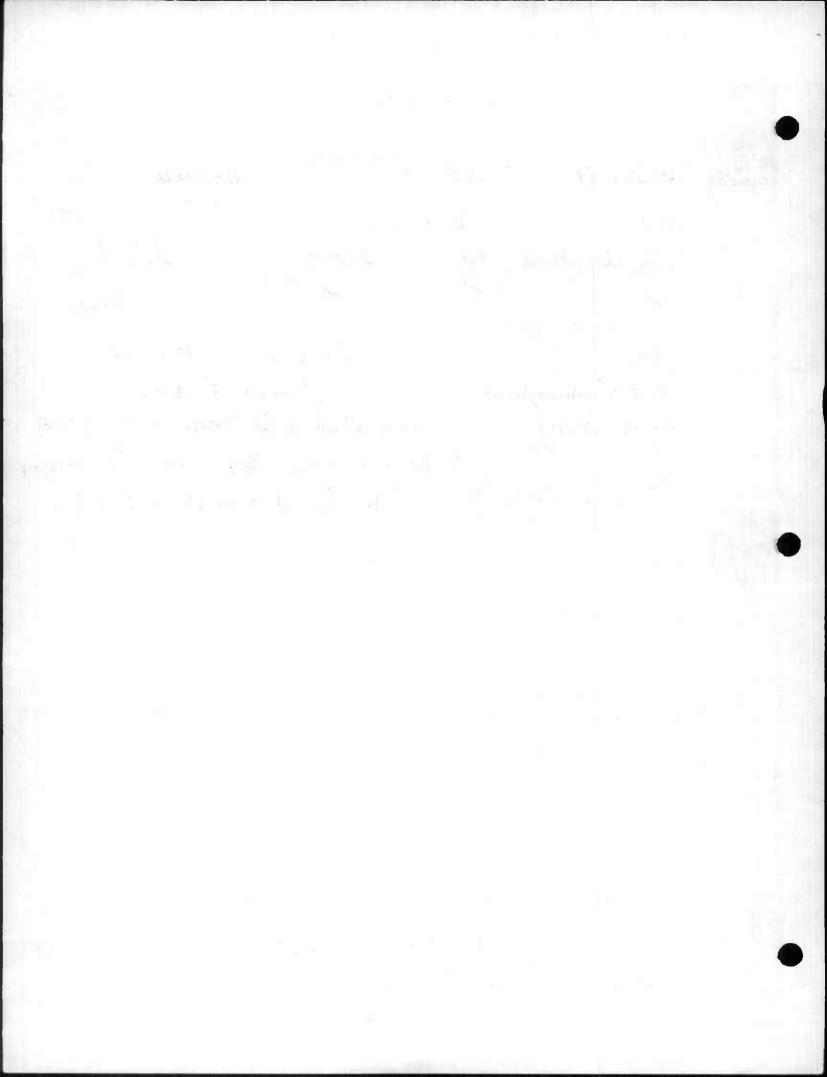
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 2 7 Month **Physician** LANKFORD FE B NEE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOSPITAL BALTIMORE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2□F 365 36 088 Director the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryla Depertment of Health end Mental Hyglene. Important: If item 27 is merked other than "natural", or items 23a or 28e-f show amy injury or other traumatic avent, the Medical Examiner must be notified at once. Baltimore 1 Ves 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 602 21239 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Blace Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) sunning ham Amanda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd Baltimore, Md. 21239 inford arah Data 20a. Method of Disposition 1 Burial 2 □ Cremation 3 MRemoval from State Plymouth 4 ☐ Donation 5 ☐ Other (Specify) Mem. Coardens 21. Senature of Funeral Service Licensae 23 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, hock, or heart failura. List only one cause on each line. 1302 N. Central Aver Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final PNEUMONIAE 20 DAYS disease or condition resulting in death) Examiner Examiner ettending physician end for use es the buriel-transit Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown RENAL 24b. Wera autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was cese referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 № Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? 1 Naturai 5 Panding investigation 1 ☐ Yes 2 ☐ No death. To the Hespital or Attendi within 24 hours efter death To the Funeral Director: A completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of injury - At home, farm, street, factory, office building, atc. (Specify) 4 T Homicide 29a. Cartifiar (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

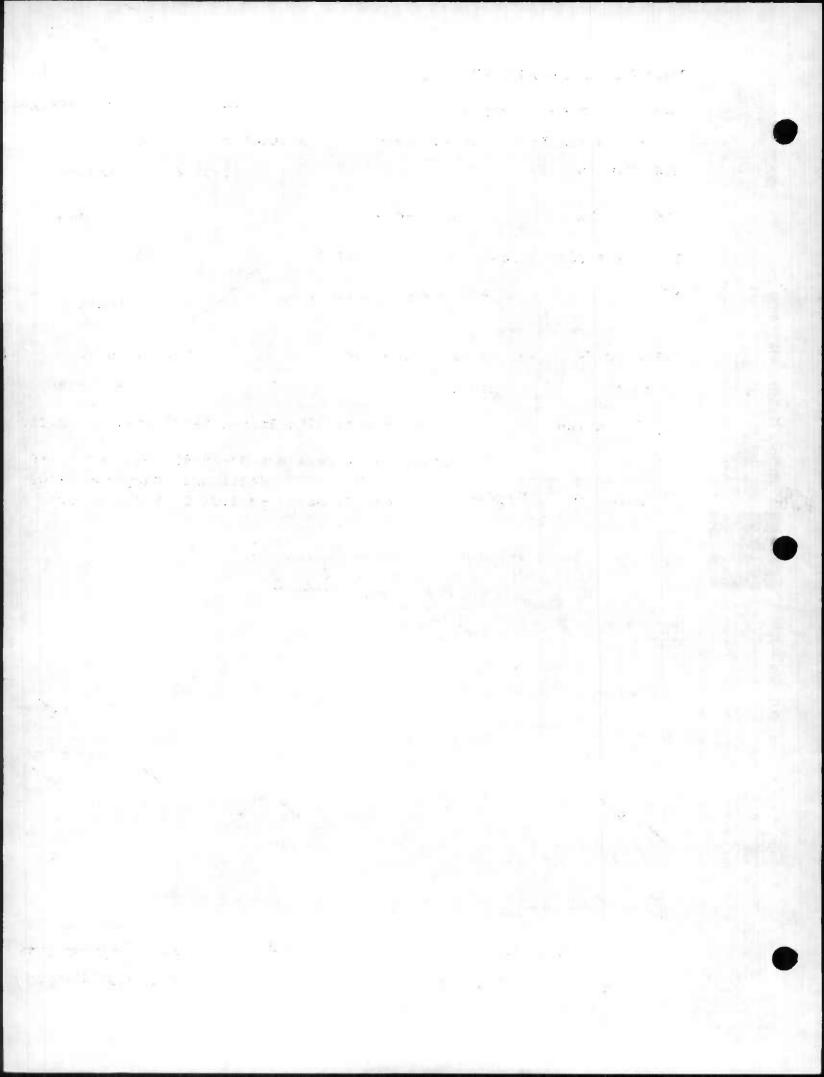
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4.1 February 27 30. Name and address of person who completed ceuse of death (Itam 23a) (Type, Print) WALID ABOUT AOUDE, MD.
Good Samaritan Hospital 5601 Loch Raven Blud Baltimore 21239 Good Samaritan Hospital

State Registrar

31. Date filed (Month, Day, Year) MAR 0 4 1998 32 Registrar's Signatura with Davidson Gandall



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 30 HELEN FEB 1998 27 a.m 4a. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth GOOD SAMARITAN HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) 1□M 2√F Deys Yrs 214-30-7488 63 10/01/34 MARYLAND Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No BALTIMORE TOWSON 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1608 HARDWICK ROAD 21286 U.S.A. 12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, GiveX Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No 3. □ Widowed 4 □ Divorced Specify: WHITE 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 11TH 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) THOMAS L. MOONEY MARIE KNIGHT 19e. tnforment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DEBRA A. SOUERS / DAUGHTER 1608 HARDWICK ROAD: TOWSON, MD 21286 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 Burial 2 Cremation 3 Removel from Stete 4 Donetion 5 Other (Specify) DULANEY VALLEY MEM. GAR. 03/02 COCKEYSVILLE, MD 21. Signeture of Funerel Service Licensee 22 Name end Address of Fecility JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD.: TOWSON, MD 21286 23 art. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such es cardiec or respiretory errest, speck, or heert feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Death · MYOCARDIAL INFARCTION Immediete Ceuse (Finel diseese or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1⊠Yes 2□ No 3 Probably 4 Unknown EN SION 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Was an autopsy performed? ABETUS MELLITUS 1 Yes 2 NO 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ≥ Inpatient 2 □ ER/Outpetient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to the cause(s) and menner stated.

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Certification:

29e. Certifier

29b. Signeture end title of certifier

Funeral

Director

permit. Pegas 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, my Marical Examiner Injury be notified.

Physician

/Medical

Examiner

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funeral director,

Baltimore, Maryland 21215-0020

To the Hospital of within 24 hours a To the Funeral D completely filled edical State Registrar

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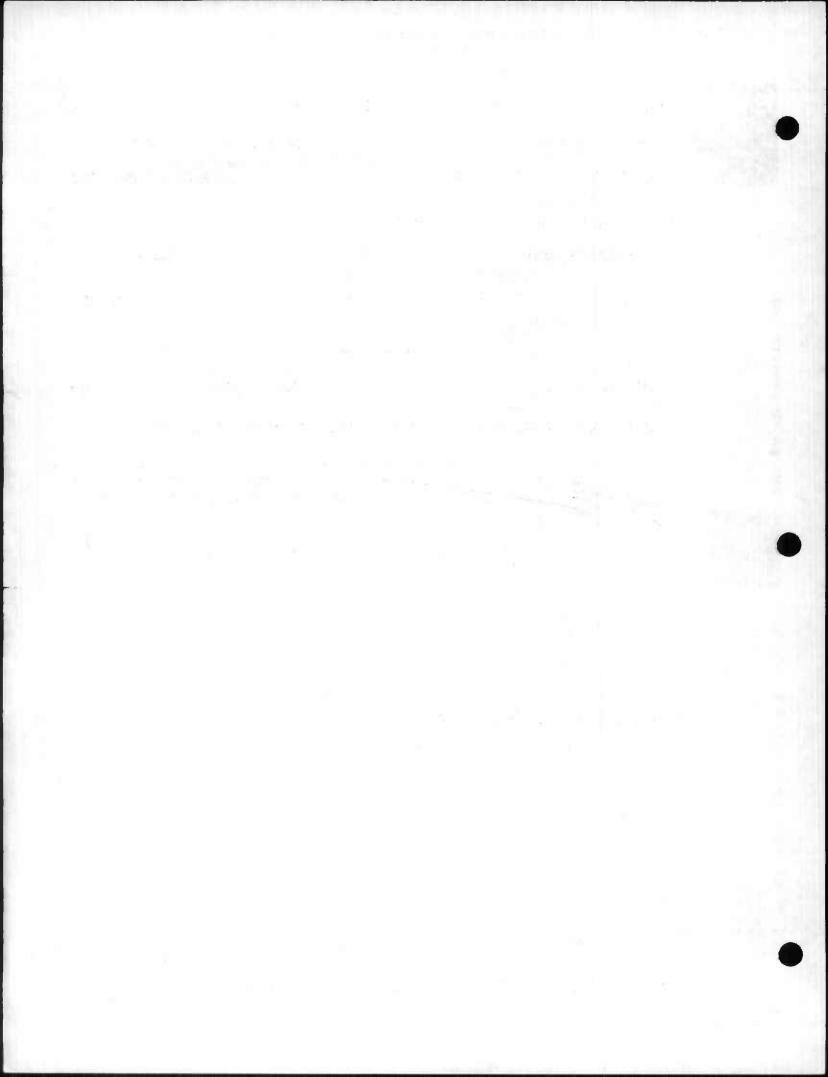
29c. License number

29d. Dete signed (Month, Dev. Year)

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

M. D

TOIZ LACHLAN CIRCLE APT # I BALTIMORE,
M N 21239 FADI MIN-EL MERHI



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death FEBRUARY 27, 1998 22:02 MARGARITAS ALEXANDER 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SAINT AGNES HOSPITAL, 900 CATON AVENUE If Undar 24 Hrs. 5 Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) Days 1 M 2 □ F 212-22-8890 JULY 21, 1926 PENNSYLVANIA Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No BALTIMORE CITY MD 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 609 WELLESLY STREET 21229 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 14. Raca - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Myas 2 No Myes, Giva Yaar or Datas: WWII 1 Navar Marriad 2 Married 1 ☐ Yas 2 X No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) MUSICIAN 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) JOHN MARGARITAS HELEN ZAREVA 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) BALTIMORE, MD 21229 NICHOLAS MARGARITAS (BROTHER) 518 OVERDALE ROAD 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1X Burial 2 Cramation 3 Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 3/4/98 WOODLAWN, MD GREEK ORTHODOX 22. Nama and Addrass of Facility WITZKE FUNERAL HOMES, INC. 21. Signature of Funeral Service License 1630 EDMONDSON AVE CATONSVILLE, MD 21228 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) My o cardial Dua to (or as a consaquance of) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated evants rasulting In daath) Last Dua to (or a a consequence of) hy semi Dua to (or as a consequence of): os clerotavessel discus Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 20 No 1 ☐ Yas 2 ☐ No 28. Place of Death (Check only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiena. Introcrant: if them 27 is merked other than "natural", or then any injury or other traumatic avains.

Baltimore, Maryland 21215-0020

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physician a certificate #

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Division of Vital

State Registrar

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Certification:

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Ebrury 27, 1998

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30. Nama and addrass of person who completed causa of leath (Itam 23a) (Type, Print)

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CATON AVE

KRAIG A. Melville 31. Data filed (Month, Day, Year) 4

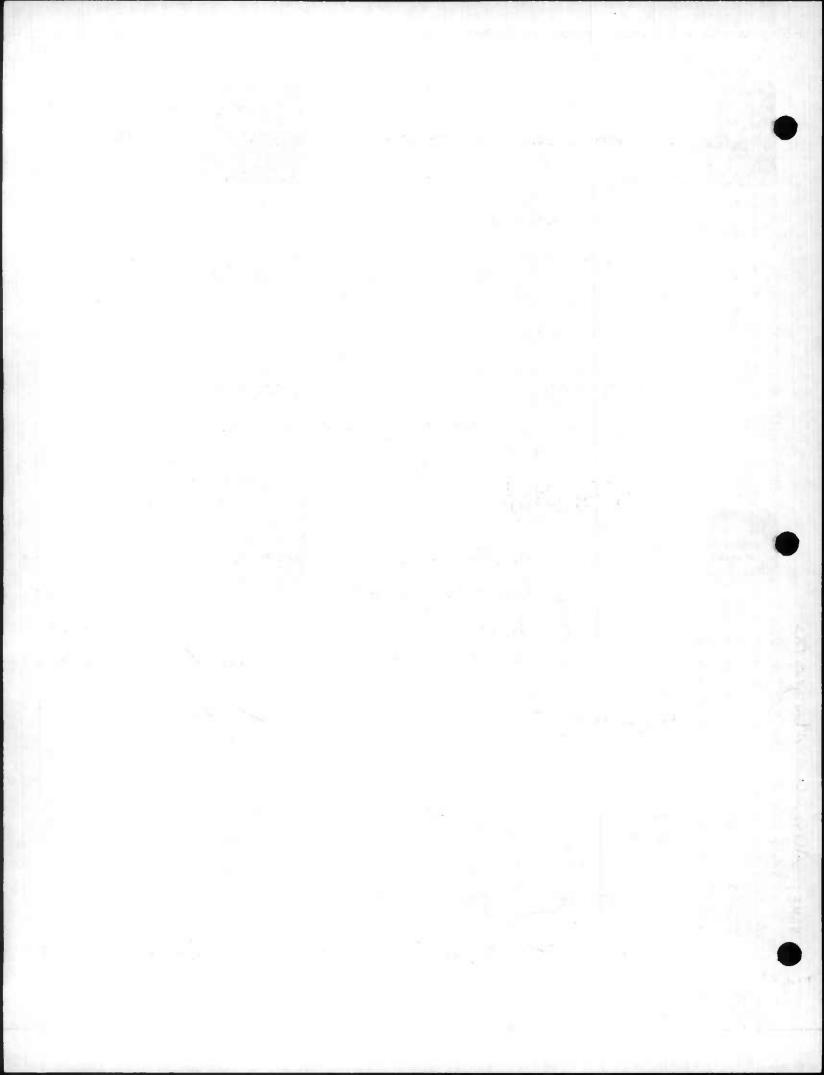
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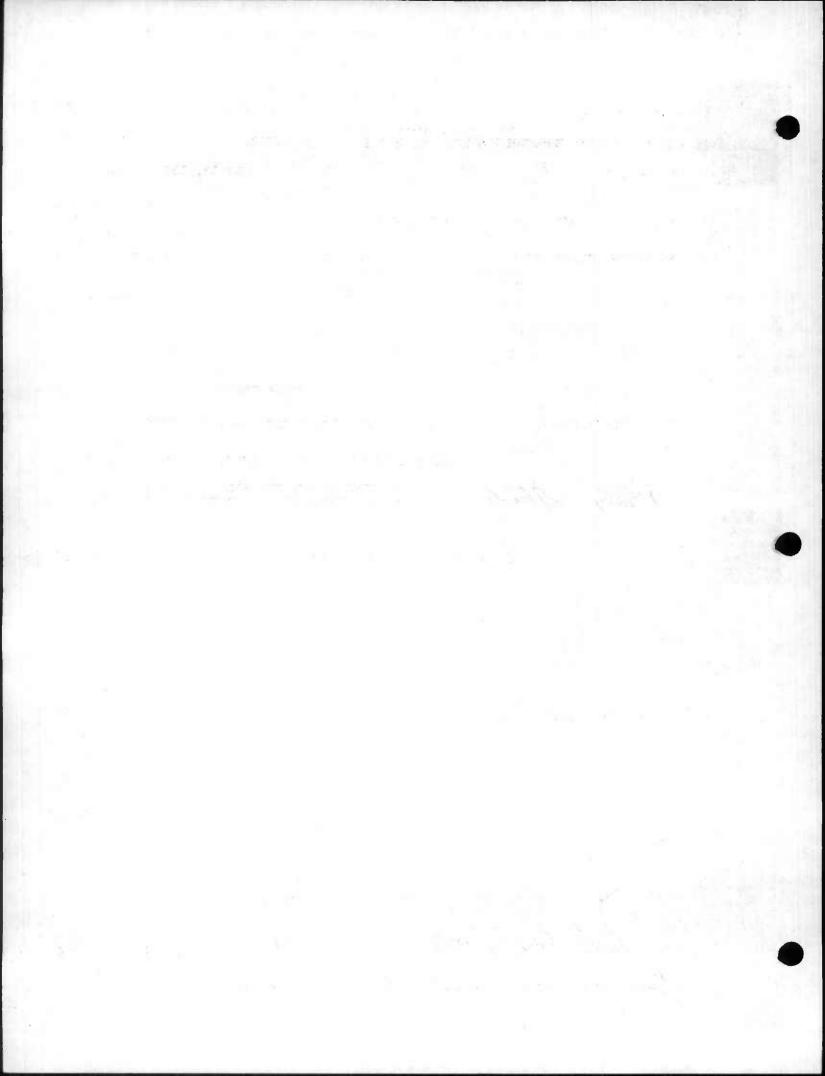
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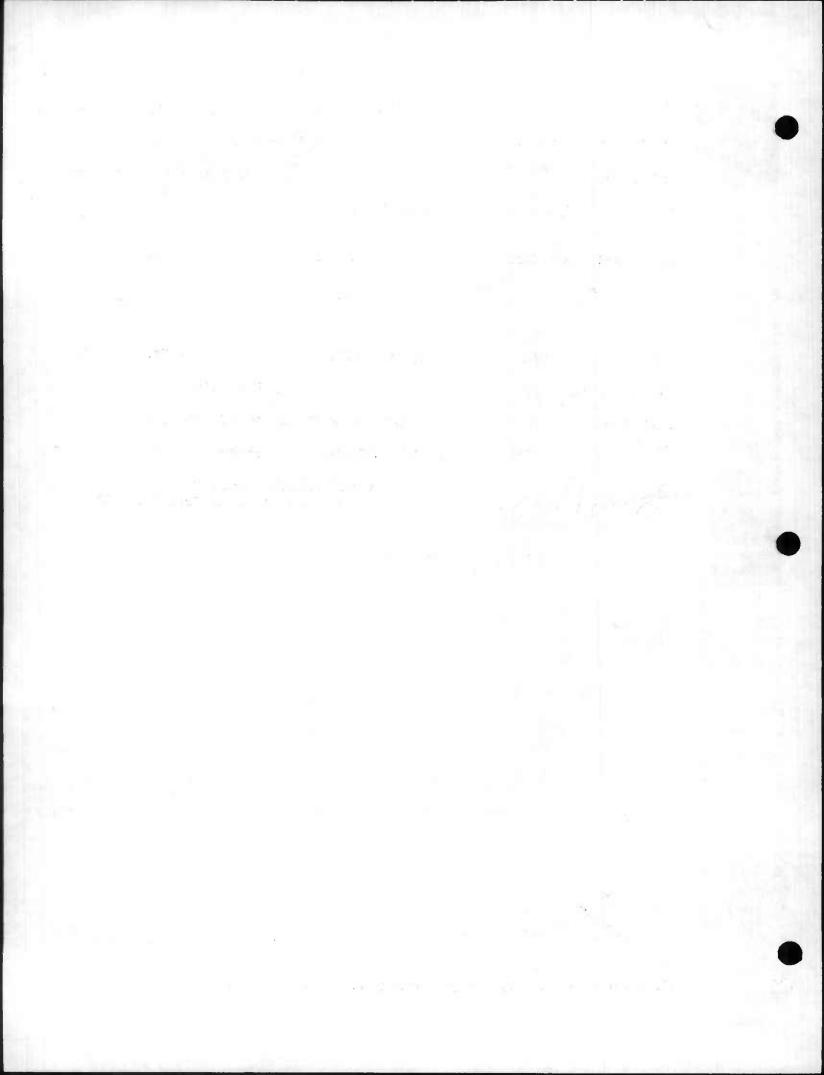
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Exam Funera Directo	al	5. Social Security N 413-26-1	lumber 6.	Ve street end number 820 1 OUSE BALT Sex 7. A	NORTH I IMORE, Age (In yrs. Ia:	MD 21	STREET L201 If Under 1 Year Months Days	BALTIM If Under 24 Hr Hours Min	ORE	irth Pey, Year)	N/A	(Stete or Foreign
aryland show	_	Usuel Residence of 10a. State	10b. County			Town or Lo						Inside City Limits
No M	Director	MD	N/A		BAI	LTIMOF						1 √Yes 2 No
with t		10e. Street and Nur					10f. Zip Code			1 1	What Country?	
72 hours effer deeth with the Maryland 72 hours effer deeth with the Maryland 7astural!, or items 23a or 28a-f show edical Examinant must be notified at	by Funeral	11. Marital Status	H FULTON	12. Was Deceder Armed Forces 1 2 Yes 2 If Yes, Give	s?] No	11	21223 Vas Decedent of No i Yes, specify Cub	Hispanic Origin?	(Specify Yes or Norto Rican, etc.)	Ble	.A. ce - Americen Ir ack, White, etc.	ndian,
C .	Completed b	-	15. Decedent's E ify only highest gr	Year or Dates (ducetion ede completed) College (1-4or	r 5+)	16a. Deced (Give) life. L	lent's Usual Occup kind of work done OO NOT use retire	pation during most of w d)	rorking		Business/Industr	у
be filed withintel Hygiene. d other than		17. Father's Name	(First, Middle, Last		1	MERCHA	71A T	18. Mother's N	ame (First, Middle			
d 2 should be the end Mentel 7 Is marked of traumetic ever	To Be	LANDON M				19h Meilin	g Address (Street	VIOLA	BREWER			* (a)
nd 2 sho alth end 27 Is m		ROGER MIL					PALCON RI			N 37814	i, 3ieie, 2ip Coo	10)
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permit. Pages Department of Important: If its any Injury or o	a la	21. Signatur 9 Fu			MIL	STE	Name and Addre	SHTON FU	NERAL HO	ME, INC		N
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death certi	clan	Port II Other eleviti	loopt conditions	and allow the standards.	hud and unauth	in a la sha wa	al all divine a second at	and Boat	one pie	4444444		-4 -4 - 14
hat the	by Physician/M	Diahe	ofes me	contributing to death	but not result	ing in the un	idenying ceuse gr	ven in Paπ I.		Yes 2 No	3 Probably	y 4 Unknow
e law requires that hes been signed b	Completed b								24a. Wa	s an autopsy formed?	evailab	autopsy findings ble prior to stion of ceuse h?
The ete h	Con								1 🗆	Yes 20 No	1 □ Ye	s 20 No
ding physician: The law requires the this cardificete has been signed funeral director, page 2 should be	ion: To Be	25. Wes cese referrexaminer? 1 Yes 2 27. Manner of Deeth 1 Natural	No 5 ☐ Pending	Hospital: 1 Inpat	jury 2	7/Outpatient 8b. Time of Injury	28c. Inju	ner: 4 Nursing	Home 5 Res		her (Specify)	Jospice
or Atten effer deat Director:	Certification:	2 Accident 3 Suicide 4 Homloide	Investigatio 6 Could not be determined	e 28e. Place of tr	njury - At hom ofc. (Specify)	e, farm, stre	eet, factory, office	.00 2 140		(Street and Num own, State)	ber or Rurel Ro	ute Number,
2.5 6/6	fedical	one)	2 Medical Exar	nysician: To the besi niner: On the besis end manners	of exeminatio	edge, death n and/or inv	estigation, in my o	opinion, deeth occ	ce, end due to the curred at the time	, date and place	, and due to the	cause(s)
To the To the Comp	×	29b. Signature end	tull (Joenly	MD		29c. Licens	18587		MARCI	ed (Month, Dey,	998.
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S [.] Regis	tate trar	31. Date filed (Mont	0 4 1998	July D	avidson-	Pandall	<u>_</u>					



		. Decedent's Name (First, Middle, Las	t)		erunca	ale oi	Death	2. Dete of D	Reg. No.		3. Tima of Death
ysician	ı	RALPH		,	GIEDA	,	7.0	Month	Day	Year	
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al	5	STELLA MARIS HOS Sociel Security Number 6. Se		lest hirthda	tf Unc	fer 1 Year	TIMONIU				place (State or Foreign
			ØM 2□F 7	Van	Month	s Days	Hours Mi	s. Date of B (Month, D JUNE 2	5 1918	MAR	YLAND
		Jsual Residenca of Decedent Oa. State 10b. County	100 0	tu Tour or	Location						10.1.1.1.00.11.00
10		MD 10b. County N/A	B	ÄLTIM	ORE,	MD.					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
Director	1	Oe. Street end Number			10f. 2	Zip Code			10g. Citizen of	What Cou	intry?
O		6615 MARIETTA A	VENILE			212	14		USA		
Funeral	1	1. Marital Stetus	12. Was Decedent Ever in U Armed Forcas?	J,S. 1	3. Was De	cedent of		(Specify Yes or N			can Indian,
by Fu		1 ☐ Never Married 2☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Yaar or Dates:			2 No		ento Rican, etc.)	Speci	ck, White.	
		15. Decedent's Ed		16a De	cedent's U	sual Occu	nation		16b. Kind of E		
Completed	-	(Specify only highest gree	da complated)	(Gi	ve kind of	work done	during most of w	vorking	TOD. KING OF L	100111053/11	lousily
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		7th 7. Father's Name (First, Middla, Last)	N/A	LOIL	LL WO	IUCLIC	18. Mother's N	ame (First, Middl			
To Be		ENOS F. MYERS					MAY	JANET FI	ORA		
-		19e. Informent's Neme/Relationship (7	vpe. Print)	19b. Ma	ailing Addre	ss (Stree		Rural Route Num		. Stete. Zi	p Code)
		TERI MYERS		185	_			IPSTEAD,			
	2	Oa. Method of Disposition	20b.	Plece of Dis	sposition (A	leme of		Dete	20c. Location		own, State
		1 Burial 2 Cremation 3	Ramoval from Stata	ARKWO	OD CE	METE	RY	2/4/98	BALTIM	ORE C	CITY, MD.
۵	1	4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sarvica License			22 Name	and Addr	ess of Fecility	3/4/98			
		191 11-			HAF	TLEY	MILLER	FUNERAL			
	-	23a. Part1. Enter the discuss, or comp shock, or heart fallural List only o	ller.					BALTIN		. 21	L234 Approximete
Examiner	1		b	or es e cons							
		Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	С.								
edical		that initiated events resulting in death) Last	Due to (d	or as a cons	sequence o	f):					
2			d								
Cla	P	ert it. Other significant conditions co	ntributing to death but not re-	sulting in the	underlying	n gallen n	iven in Pert I	23h Die	d tobacco use c	ntribute 1	to the cause of death?
Physician/M		on the state anguithment contained to	minoding to double but not to.	suring in the	andenyan,	g vouse g	VOI 411 0/().		Yes 2 No		
d by								046 141-	s an autopsy	24h 14	Vere eutopsy findings
Completed	-								formed?	. 0	vaileble prior to omplation of causa f deeth?
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0		25. Wes case referred to medical					26 Place of D	eath (Check only			
0		examiner?	Hospital: 1 ☐ Inpatiant 2 ☐	ER/Outpat	iont all	004	hor	Homa 5 Ra		har /Snaa	HOSPICE
-	2	7. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Dey Year)	28b. Time Injur	of v	28c. Inju	ork?		how injury occu		y HOSTICE
cat		2 Accident invastigation 3 Suicide 6 Could not be	00- Di		M		Yes 2 No	004 1	(Change and A)	harri O	n/ Pouto A/ h
Certification:		4 ☐ Homicide determined	28e. Placa of Injury - At h building, etc. (Speci		street, fect	ory, office			(Street and Ivum own, Stete)	ber or Hui	rel Route Number,
edical C	2	(Check only 2 Medical Exam	elclan: To the best of my kno ner: On the basis of examine	owledge, de etion end/or	eth occurre	ed at the t	ime, dete and pla opinion, death oc	ce, and due to the	e cause(s) and m e, date and plece	anner as :	stated. to the cause(s)
Med	2	one)	and manner stated.		2	9c. Licen	ae number	-	29d. Date sign	ed (Month	, Day, Year)
) Like	40 200			41	155	4	3 . 2		8
	3	0. Name and address of person who c	ompleted cause of deeth (ite	m 23e) (Typ	e, Print)						
		DR. EDDIE NAKHUD	A 2300 DULAN	EV WA	TEV	מא	TTMONTER	M MD 21	002		
State gistrar	3	11. Date filed (Month, Dey, Year) MAR 0.4. 1998	32. Registrar's Sign	ature			* TRION TO	rı, rw Zl	U73		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Daath Month Yae **Physician** Sr. Treorat T. Nemohos February 27, 1998 11:36 A.M. /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center Rosedale Baltimore If Undar 24 Hrs. Hours Min. 9. Birthplaca (Steta or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year 8. Data of Birth , (Month, Dey, Year) 6 Sax **Funeral** Months Deys 12M 20F 78 16 3606 Yrs. Director November 13 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours ofter deeth with the Maryland nent of Health and Mental hygiena. ant: If Item 27 is marked other than "naturel", or items 23a or 28a-f show ary or other traumatic event, the Medical Examines from the notified at 10a State 10d. Inside City Limits 10b County 10c. City, Town or Location Baltimore 1 ☐ Yes 2 Z No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21234 USA 3320 Acton by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indien. 11. Merital Stetus Bleck, White, etc. 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: 1 Navar Marriad 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) General Electric Purchasing Agenl 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Nemphos MATY Granito **I**homas 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) important: If Item 27 is any injury or other tra once. Parkville Doris Nemphos 3320 Acton Rd Maryland March 4 20e. Method of Disposition 20b. Piece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 1. ■ Buriel 2 □ Cremetion 3 □ Removei from State Baltimore Cemeter 4 ☐ Donetion 5 ☐ Other (Specify) PARKWOOD 1998 22. Nama end Address of Facility 21. Signature of Funeral Service Licenses MS Chapel of HAVLORD Rd. Memories EVAMS Baltimore Md 21234 8000 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medicai Immediate Ceuse (Final disease or condition resulting in deeth) a. Ruptured Abdominal Aortic Aneurysm 10 Hours Examiner Due to (or es e consequenca of) Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initieled events resulting in deeth) Last Due to (or es e consequenca of): Physician/Medical Dua to (or as a consequence of) 23b. Did tobecco use contribute to the cause of deeth? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause givan in Pert I. 2 No 3 Probably 4 Unknown 1 Yes P 24b. Were eutopsy findings eveilable prior to completion of causa of deeth? Completed 24a. Wes en eutopsy performad? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Chack only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Megnar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation

physician Division of Vital Records, P.O. Box 68760 The lew requires that the death certificate signed by the e i certificate has t lirector, page 2 s

yearge Thomas Nemphos

Hospital or Attending Physician: 1 24 hours aftar death. Funeral Director: After this certifical stelly filled in by the funeral director, p in 24 hour. The Funeral Direction

To the Hosp within 24 hor To the Fune completely fi

State Registrar

Medical

1th Certifying Phyelcien: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifier (Check only one)

6 Could not be

29b. Signature and titla of cartifier

29c. License number

29d. Date signed (Month, Dey, Yaer)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

February 27, 1998

30. Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print)

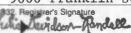
9000 Franklin Square Drive Baltimore, MD Stuart Willes M.D.

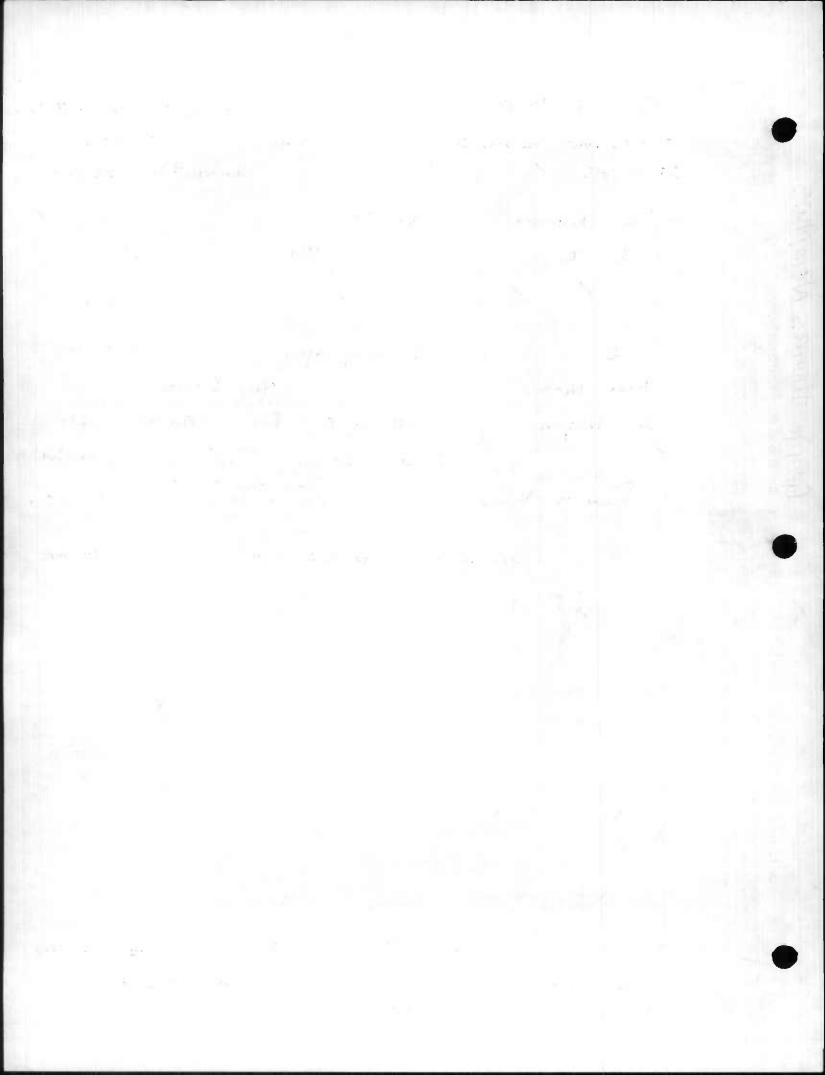
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Dete filed (Month, Day, Year) MAR 0 4 1998

3 Suicide

4 Homicide

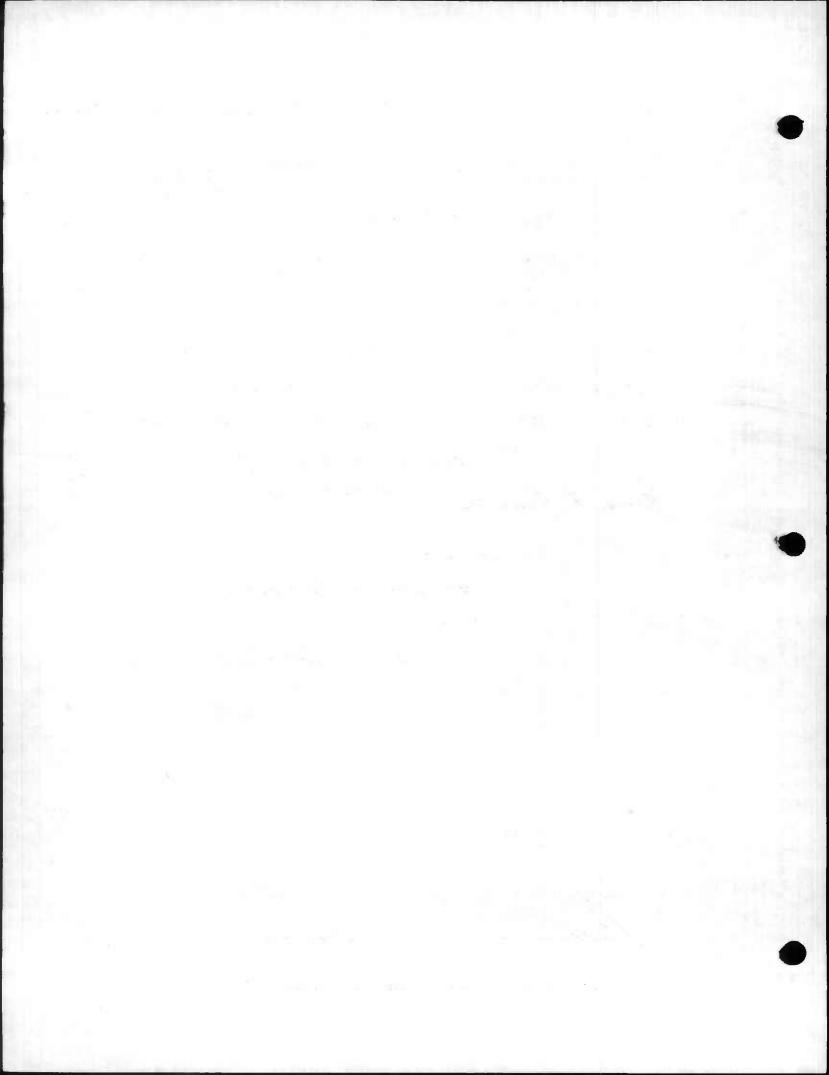




State of Maryland / Department of Health and Mental Hygiene 98 05693

					Ce	rtificat	e of	Death			Reg. No.		0000	
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Physic /Medi		RITA			N	EE				Februa	ry 28,	1998	7:40 a.	
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		STELLA MARIS						TC	ORWO	V		BALTI	MORE	
Funeral		5. Social Security Number 6	Sex 7. Ag	e (In yrs. lesi		If Under Months	1 Year Deys		24 Hrs. Min.	8. Dete of Bid (Month, De	ev. Year)	9. Birth	nplece (State or For	
Director		220-09-3486	10 M 20 F	79	Yrs.					MAR. 1	4, 191	8 MA	RYLAND	
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within 72 hours effer death with the Maryland ens. than "neturel", or items 23s or 28s-f show the Madical Everginer must be notified at	5	MARYLAND BALTI	10RE	OWIN	IGS M	ILLS						1 □ Yas 2 🕏		
288	Director	10e. Street end Number				10f. Zip	Code				10g. Citizen	of What Co	untry?	
ours enter deaun with the maryle eli, or items 23a or 28a-f shov Examiner must be notified at		5216 WAGON SHED	ידים די					21117	7			.S.A.		
items 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U,S.	13.	Wes Deced	dent of I	Hispenic Orl	gin? (Sp	ecify Yes or No		-	ricen Indien,	
or its		1 ☐ Never Married 2 ☐ Married		No		_		uban, Mexicen, Puerto Ricen,				Bleck, White		
0.1	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	1 ☐ Yes	2X No	Specify:			Spe	ecity: WH	ITE	
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end Mental Hygiena. s marked other than sumatic event, tre Me	Be	17. Fethar's Name (First, Middle, Le	st)					18. Motha	ır's Name	a (First, Middla	, Maidan Sun	nama)		
marked marked imatic e	2	IRA WASHINGTON LA	DWMAN					MAI	RY E	. HEALY				
		19a. Informent's Name/Relationship				-				Poute Numb				
Heal Ther		KATHRYN C. NEE,	DAUGHTER					ED CTI	KCLE	, OWING				
		20a. Method of Disposition 12 Burial 2 ☐ Cremetion 3	Removet from State	cemi	etery, crei	natory or o	ther ple	000)	1_	Dete	20c. Locatio			
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Important land		21. Signeture of Funerel Servica Lic	ansea	22. Neme end Address of Fecility W									· · · · · · · · · · · · · · · · · · ·	
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		23a. Pert1. Enter the disease, or co shock, or heart feilure. List on	mplications thet ceused y one cause on eech lir	the death. [ne.	Do not ent	er the mod	la of dyi	ng, such es	cerdiac (or respiretory e	rrest,		Approximete Intervel Between	
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physician and is the burial-trans	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying		Due to (or es								i		
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e ett	Physician	Pert II. Other algnificant conditions	contributing to death be	ut not resultin	a in the u	nderlying c	euse ai	ven in Pert I.		23b. Did	tobacco use	contribute	to the cause of de	
by the	hy					7.0					Yes 2□N			
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been si											en eutopsy ormed?		Vere autopsy findin	
85 CA	pie											0	ompletion of cause daath?	
ate he	Completed									10	Yes 2 No	0 1	☐Yes 2☐No	
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After th funeral		27. Manner of Daath 1 ANetural 5 ☐ Pending	28e. Date of Injur (Month, De)		b. Time o	2	8c. Inju Wo	ry et rk?		28d. Describe	how injury oc	curred		
or: A	catl	2 Accident Investiget				М	1 🗆]Yas 2 □ I	No					
aner daam. Director: Af d in by tha fu	Certification:	3 ☐ Sulcide 6 ☐ Could not datarmine		ury - At home c. (Specify)	, ferm, str	eet, factory	, office			28f. Location (City or To	Street end Nu wn, Stata)	ım <i>ber</i> o <i>r R</i> u	ral Route Number,	
led		00-0-11								City or Town, Stata)				
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of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Direction of the Funeral Property Filled in Experimental Property Fi	Mec	29b. Signature and the of certifier	end menner ste			290	, Licen	se number			29d. Date sig	ned (Month	, Dev. Year)	
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W.	1	go Nema and add												
/		30. Neme end addrass of person wh						mr	~ 7 7 7 -	MD 011	202			
CA	to.	DR. EDDIE NAKHU 31. Dete filed (Month, Day, Year)	# 32 Registre	er's Signature		LEY RI	υ	TIMON	LUM,	MD 210	193			
Sta Regist		MAR 0 4 1998	Julianary	doon-ha	ndell									
3		INFIN U = 1000	C/	*										

DHMH 16 Rev 6/95



98-1027-510 jhm DANTE **POWERS Physician** /Medical Examiner **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours aftar deeth with the Maryler Department of Health end Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Example or notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0020

	State of M	laryland / [Departmo Certific				lental Hy	/giene Reg. No.	96	3 (06694
Decedent's Name (First, Middle, La.	st)						2. Dete of De		•		3. Tima of Death
DANTE	(Power	2 (Month	Day		Yeer	00-16 334
4a Facility Name (If not institution, giv		-	67		4b. City, To	own, or Lo	FEBRU ecation of Dear		26,1 County		100:16 AM
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5. Sociel Security Number 6. S		ge (In yrs. lest bir	thdey) If Ur	dar 1 Year		r 24 Hrs.	8. Date of Bi	irth	1	9. Birthi	place (Steta or Foreign
	12 M 2□ F	18	Yrs. Mont	hs Days	Hours	Min.	(Month, D	ey, Year)	9	MA	ry CANCI
10a. State 10b. County		10c. City, Tow	n or Location								10d. Inside City Limits
mil w/n		Rais	truor								1 Yas 2 □ No
10e. Street end Number		10130	- 1	Zip Code				10a. Citi	izen of W	Vhat Cou	ntry?
2610 HAY FOR	1	0.1		2121	8						
11. Marital Status	12. Was Decedent	Ever in U.S.		61 101	0	ngin? (Sn	ecify Yes or N		14. Race		can Indian,
1 Navar Married 2 Marriad	Armed Forces	?/	If Yas,	pecify Cub	en, Mexica	n, Puerto	ecify Yes or N Rican, atc.)			k, White,	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:		1 🗆 Ye	2 No	Specify	r:			Specify: /c		LACK
15. Decedant's Ed (Specify only highest gre		16a	Decedent's U (Give kind of life. DO NO	sual Occup work done	ation during mos	st of work	ing	16b. Ki	ind of Bu	siness/Ir	ndustry
Elamantary/Secondary (0-12)	Collaga (1-4or	5+)		mpt.					Noi		2
17. Fathar's Neme (First, Middla, Last)	1			-	18. Moth	er's Name	(First, Middle	e, Meiden	Sumem	e)	
Reginald	Pow	ers			Ed	ith	Whi	TF	iel	d	
19a. Informent's Name/Relationship (Edith White	Type, Print) (C(- Mo		o. Mailing Addi 2610 H								
20a. Method of Disposition		20b. Place o	Disposition (Nama of	ce)		Data	20c. Lc	ocation -	City or T	own, State
1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi		Vos	CHEL	L Co	meta	ery 3	14/98	13	set	imo	, md. 21213
21. Signature of Funeral Servica Licer	1500		22. Name	and Addra	ss of Facil	lity	14/14	300	ction	Love	, Md. 21213
Jeff mel	en		JEFI	= me	ILER	P.C.	Fun	can	L 4	ome	+ Service
23a Part Frier the disease, or com shock or heart failure. List only	plications that cause one cause on each	d the death. Do line.	not antar tha r	noda of dyl	ng, such as	s cardiac	or respiratory	arrest,			Approximeta Interval Between Onset and Death
Immediate Cause (Final	(.	1 -1 - 1	1. 1	1	rho.	Bar	1.11				
disease or condition resulting in deeth)	a. Guns		10und		0	Jun				- 1	
		Due to (or es a	consequenca	of):							
Sequentially list conditions,	b	Dua to (or es e	consequance	of):							
if any, laading to immadiate cause. Enter Underlying		(5. 30 0									
Cause (Disease or injury that initiated events	C	Due to for se s	CONSEQUENCE	of).							
resulting in death) Last		Due to (or as a	consequence .	υι <i>)</i> .							
	d									1	
Part II. Other algnificant conditions of	ontributing to death I	but not resulting I	n the underlyin	ng causa gi	van in Pert	1.	23b. Dic	tobecco	use cor	ntribute 1	to the cause of death
							1	Yes 2	S-Ro	3 Pro	obably 4 Unknow
							24a. Wa	s an eutop formed?	psy	C	Vara autopsy findings veilable prior to ompletion of cause f daath?
							19	Yes 2	□No	1	Ş-Yes 2□ No

attending physic peen

Completed by Physician/Medical Examiner Be Certification: To

Medical

Physician /Medical Examiner

To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2:

Division of Vital Records, P.O. Box 68760

Registrar

David 31. Dete filed (Month, Day, Year) State 0 4 1998

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

29b. Signature and title of cartifier

1 Natural

2 Accident

4 Homicide

3 ☐ Sulcide

29a. Cartifiar (Check only one)

5 Pending invastigation

6 Could not be determined

30. Name and eddress of person who complated cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Dey Year)

2-25-98

1 Certifying Physicien: To the best of my knowledge, daeth occurred et the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the time, deta and place, and due to the cause(s) and manner stated. 29c. License number

28c. Injury at Work?

1 Yes 2 No

26. Place of Death (Check only ona)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

subject

28d. Describe how injury occurred

29d. Date signed (Month, Dey, Year)

28f. Location (Straet and Number or Rural Routa Number, City or Town, State)

OCME FEBRUARY 26, 1998

111 Penn Street, Baltimore, Maryland 21201

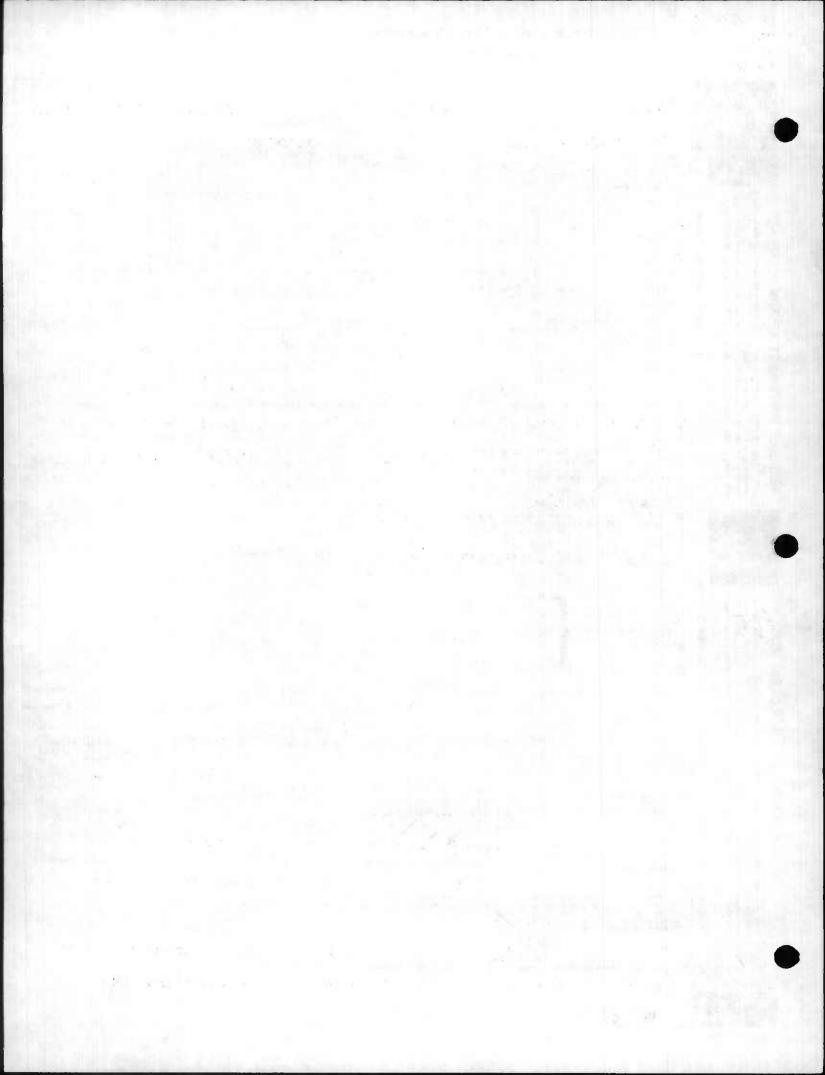
Registrar's Signature Devidson gandall

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

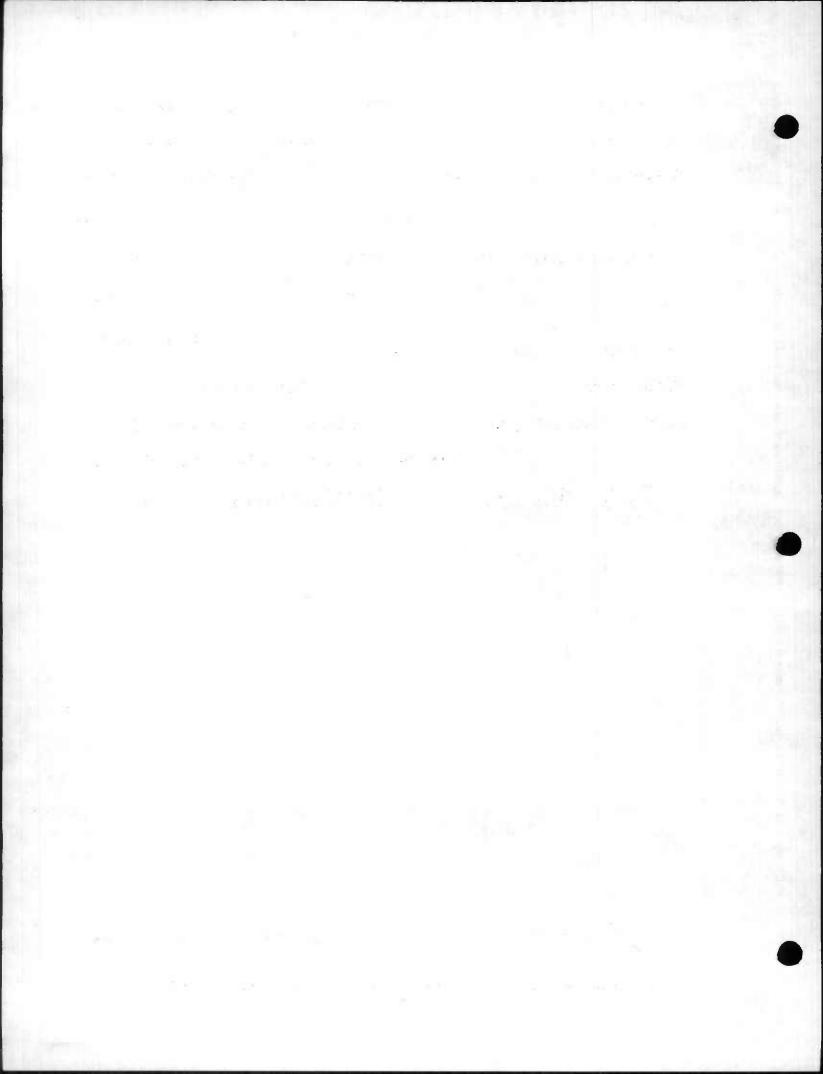
28e. Placa of Injury - At home, farm, straet, factory, offica building, etc. (Soecity)

28b. Time of

23 50 M



nysici		1. Decedent's Name (First, Middla	, Last)		Ce	incate	of Death	2. Date of D	Reg. No.	98 (3. Time of Death
Medi		CATHERINE			Р	AIGE	- t	Februa	ry Days	-5 -1 -	6:00 p.n
kamir	ier	4a. Facility Name (If not Institution,	give straat and nui	mber)				, or Location of Dea	ith 4c. C	ounty of Deeth	
1		Stella Maris 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Y	Towson ear If Under 24			ltimore	ace (Stata or Foreign
neral ector		220-18-6988 Usual Residence of Decedent	1□ M 2/C/XF	78	Yrs.	Months D	ays Hours I	Min. (Month, E 12-1-1	Pay, Year)	Coun	.C.
12		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				1	Od. Inside City Limits
Examiner must be notified at	to	Md N/	А	В	altimo	re					1√Yes 2□No
	lrec	10e. Street end Number				10f. Zip Co	de		10g. Citize	en of Whet Coun	try?
	rai	201 N. Washin	gton Stre	et		21231			U	SA	
	Funeral Director	11. Marital Status	Armed Fo			Was Decedent If Yes, specify	of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	lo- 14	Raca - Americ Black, White,	
	by F	1 ☐ Never Merried 2 ☐ Marrie 3 Ø Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Giv Year or D	9		1□ Yes X⊠	No Specify:		s	Specify: B	ack
	Pa	15. Decedent	s Education		16a. Dece	dent's Usual O	ccupation		16b. Kind	d of Business/Inc	lustry
	Completed	(Spacify only highas) Elementary/Secondary (0-12)	grada complatad) College (1	-4or 5+)	(Giva	kind of work d DO NOT use re	one during most of	working		al Secur	
	Con	5th grade	N/A		Cle	erk					
	Be	17. Father's Name (First, Middla, L	ast)					Name (First, Middl	a, Maidan S	umama)	
	2	Sandy Boyce					Mamie				
		19a. Informant's Name/Relationsh						r Rural Route Num			Code)
		Jeanette Watki	ns-Daught	20h I	Diago of Dieno	LaRue	of .	Baltimor		21225 ation - City or To	wn State
ouce.		1)(Bunal 2 Cremation		State	cematary, crai	natory or othai	place)				
		4 ☐ Donation 5 ☐ Other (Sp 21. Signeture of Funeral Service L		\ \ \	9	orial Name and A	Park ddress of Facility	3-5-98	Randa	allstowr	, Md
o lile		VX (1)	21	,		March F 4300	/H West	Avenue		nore, Mo	
an al er	ner	Immediate Cause (Final disease or condition resulting in death)	a. Bre		Cun or as a consec					1	Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or as a consec	juenca of):					
	edical	Cause (Disease or Injury that Initieted events resulting In death) Lest	c	Due to (d	or as a conseq	uenca of):					
	clan		-							Ì	
		Part II. Other significant condition	s contributing to de	ath but not res	ulting In the u	nderlying caus	e given in Pert i.	23b. Die			the cause of death?
	hys							4.5		No 3 Prot	ably 100 Inknow
	y Physician/M							10	Yes 2∟		·
	by							24a. Wa	s an autops formed?	ava	are autopsy findings illable prior to inpletion of cause death?
	by							24a. Wa	s an autops	ava cor of	illable prior to apletion of cause
		25. Was case referred to medical					26. Place of	24a. Wa	s an autops formed?	ava cor of	illable prior to appletion of cause death?
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	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 Aloo 27. Manner of Death 1 Aloural 5 Pending Investige	28a. Date of (Month		ER/Outpatier 28b. Time of Injury	28c.		24a. Wa per	s an autops formed? I Yes one) sidence 64	No 1 C	illable prior to impletion of cause death?
	o Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending	28a. Date (Moni	of Injury h, Day Year)	28b. Time of Injury	28c.	Other: 4 Nursin	24a. Wa per 1	s an autops: formed? I Yes one) sidence 64 s how injury	No 1 C	ilable prior to moletion of cause death? I Yes 2 No HOSPICE
	Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending Investiga 3 Suicide 6 Could nudetermin 29a. Certifier	28a. Date (Moni	of Injury h, Day Year) of Injury - At h ng, etc. (Spacia	28b. Time of Injury ome, farm, str	M 28c. M eet, factory, of	Other: 4 Nursin	Death Check onlying Home 5 Res 28d. Describe 28f. Location City or Total aca, and due to this	s an autops formed? I Yes one) sidence 6- how injury (Street and own, State)	A average of the control of the control occurred Number or Rura	illable prior to molecular in poletion of cause death? I Yes 2 No HOSPICE I Routa Number,
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Defe of Deeth **Physician** DOROTHY GASTON Van PELT Bych /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of De Examiner 8011 York Road, C-1 Baltimore County Towson If Under 1 Yeer If Under 24 Hrs. Hours Min. 5. Sociei Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2]X)F Deys Yrs. Director 215-07-0733 Aug. 6, 1909 Maryland the Merylend 10e Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with Funerai 8011 York Road, C-1 21286 USA 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Meritel Status filed within 72 hours efter 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry bith and Mentel Hygiene.

27 Is merked other than "r traumetic event, the Mes Elementery/Secondery (0-12) Coilege (1-4or 5+) 2 yrs Secretary Lega1 17. Fether's Neme (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Heelth and Mentel Hy Important: If item Z7 is marked otherny injury or other traumatic event one. 18. Mother's Neme (First, Middle, Meiden Sumeme) Be 2 Gaston Elizabeth Herbert Aiklev Joslyn 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) C. Arthur Eby, Jr., Esq. (P.R.) 501 Hawthorne Road, Baltimore, MD 21210 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Bunel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Parkwood Cemetery 3/6/98 Parkville, Maryland 21. Signature of Funerel Senior 22. Name end Address of Fecility Martin D. Lawson Mitchell-Wiedefeld Home, Inc. 23e. Pert1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 110 in C. 111 C.

23e. Pert1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 110 in C. 111 C.

23e. Pert1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 110 in C. 111 C.

23e. Pert1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** fmmediete Ceuse (Finei disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sa requires that the death certificate be executed physician end Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Due to (or es e consequença of) for use as Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco des contribute to the cause of death? been signed by the should be detached 10 Yes 2 No 3 Probably 4 ☐ Unknown Division of Vital Records. P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed has page 2 certificate 1 Yes 2 1-N6 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

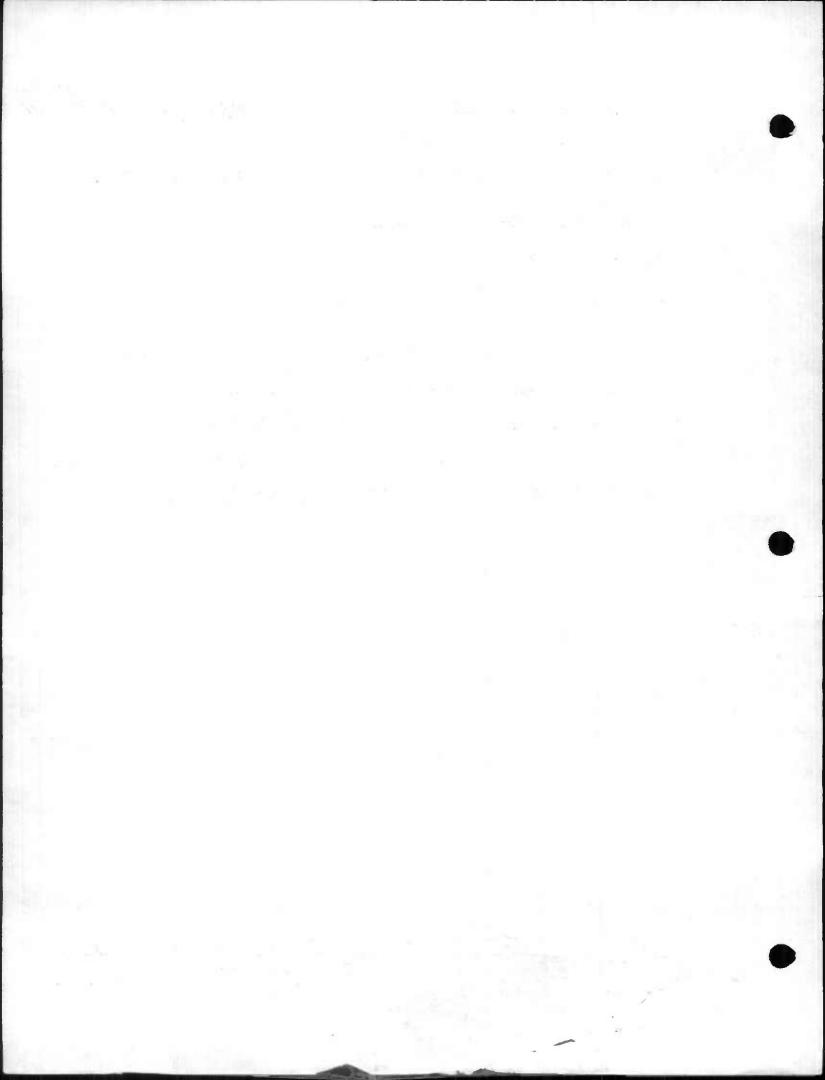
To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 Yes 2 No 2 Accident investigation 3 Sulcide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner as steted.

2 Amedical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pieca, and due to the cause(s) end manner steted. 29e. Certifier (Check only one) 29b. Signeture endutitle of certifie 29c. License number 29d. Dete signed (Month, Dey, Year) 10 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, 0 31. Dete filèd (Month, Day, Year) ornellm! 32. Registrer's Signature State

Registrar

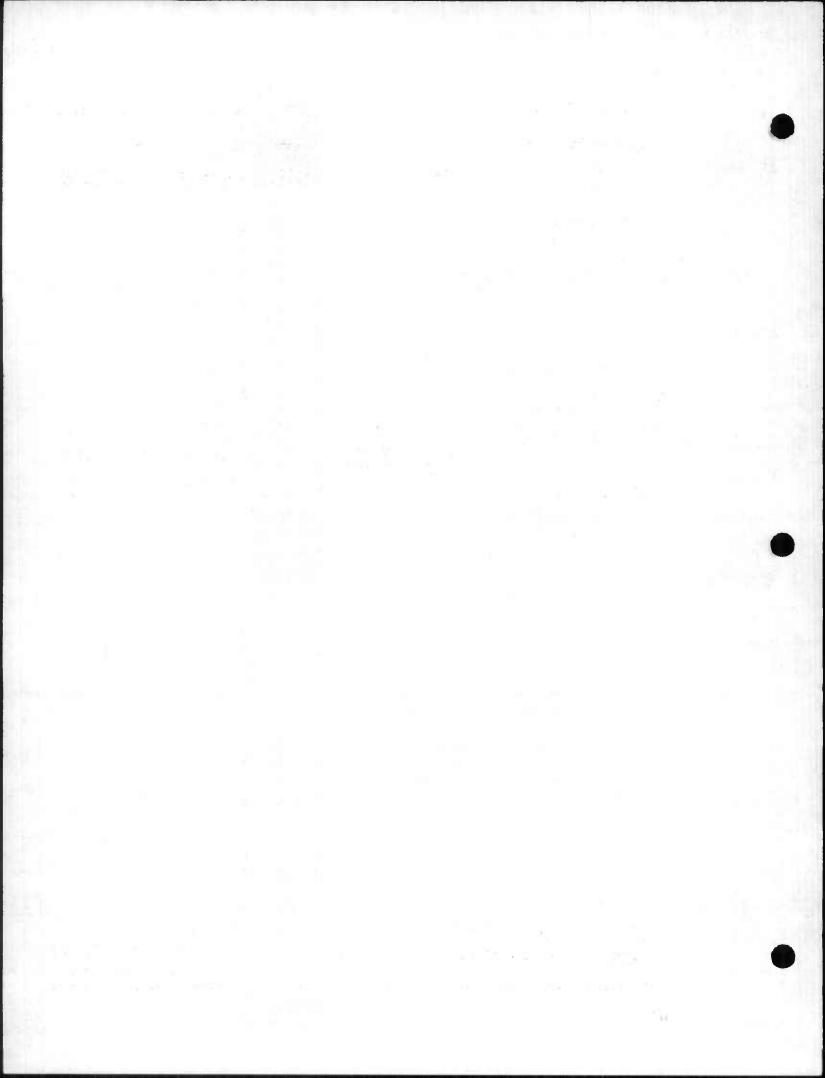
DHMH 16 Rev 6/95

1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O.

72 hours after death v natural; or forms 23s	al er	Decedant's Name (First, Midden Doris B. Pl 4e. Fecility Neme (If not institution 10461 Waterfow 5. Social Security Number 216–18–6615 Usuel Residence of Decedent	ummer on, give street end numb ol Terrace	ber)					Month	Dey	Year	3. Time of Death
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requires that the death certificate be assouted open signed by the attending physician and ihould be detached for use as the bunal-transit	i Examiner	Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause, Oisease or Injury	5 b. CHAV.		or es a conseq	9		~~~~~	DISEASE			2 years
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Hing After fune	Certification:	Z Z Addiddin	igation	Injury Dey Year)	28b. Tima of injury	м	28c. injury Worl 1 🗆 `	yat <br Yes 2 □ No	28d. Describe h	ow injury occurr	red	
To the Hospital or Attend within 24 bours after deat To the Funerar Director: completely filled in by the	Certific	3 Suicide 6 Could 4 Homicide determ	nined 286. Piece of	f injury - At h , etc. <i>(Speci</i>	ome, ferm, stre	eet, fector	y, office		28f. Location (5 City or Tow	Street end Numb m, Stete)	er or Rural	Route Number,
n 24 bound of Full of Stally fill	edicai	29e. Certifier 1 Certifyli (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basi end menne	is of examina	owledge, deeth ation and/or inv	occurred restigetion	ed et the time, dete end place, and due to the lon, in my opinion, daath occurred at the time.			ceuse(s) end ma date and piace, a	nner es sta and dua lo	tha cause(s)
To the Comp	Ž	29b. Signeture and title of certifie	1			29	c. Licanse	number		29d. Data signed		
		you	b	AD			D	51860		MARCI	4 2	, 1998
		30. Name and eddress of person	who completed cause	of death (iter	m 23e) (Type, I ELLIC. + 1	Print)	NEW	PAILE	SUITE 107	ELC IC MARY	uno	177, 21043



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 26,1998 ROSARIO 4,30PM ARATORE FEB 4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death NA CENTER 7. Age (In yrs. lest birthday) MERCY 5. Social Security Number MEDICAL BALTO. CITY If Under 1 Yaar If Undar 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) 10 M 20 F Months Days 218-03-3639 Yrs. New YORK DEC, I, AK Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1€Yes 2□No BALTIMORE CITY NIA MD. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21202 FAWN ST. USA 011 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 22PNo If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. Navar Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 FORGER STEEL FACTORY STECL 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) UNKNOWN ARMELA MIREBILE 19a. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) RALDH FINO SR. (STEPBASTHER) FAWN ST. BALTO, 21202 Hd. 1011 20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from State Procto. 4 Donation 5 Other (Specify) DOOD LAWNCEMETERY 22. Name and Address of Facility 4 SONS FUNCERE HOME 21 Signature of Funeral Service Licenses ELLA NOCE 322 SHICH SHICK ST. 2/202 BALTO Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert fallure. Last only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) 0851 ble Rutmona Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 thknown 1 Yes 2 No

Physician /Medical Examiner

à Department in Important: If any injury or poce.

Physician

/Medical

10a State

Director

Funeral

by

Completed

Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examinet must be notified at

Pages 1 and 2 should be filed within 72 hours effer of the cline and Mental Hygiene.
The liftern 27 is marked other than "naturel" or item

Hygiene.

Baltimore, Maryland 21215-0020

the Merylenc

death

Examiner physician end the buriel-trans Physician/Medical the SB esn

0

Division of Vital Records, P.O. Attending Physician:

certificete be exec ed by the detached signed by the þ Completed funerel director, Be 1º this Certification: After ie Hospital or Attending n 24 ffours efter death. ie Funeral Director: Afte

10

To the within 2

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certific

4

MAR

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24e. Was en autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 propatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□No 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 DNatural 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner es stated.

2 Medical Examinar: On the basis of examinetion and/or Investigetion, In my opinion, death occurred et the time, date and piece, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

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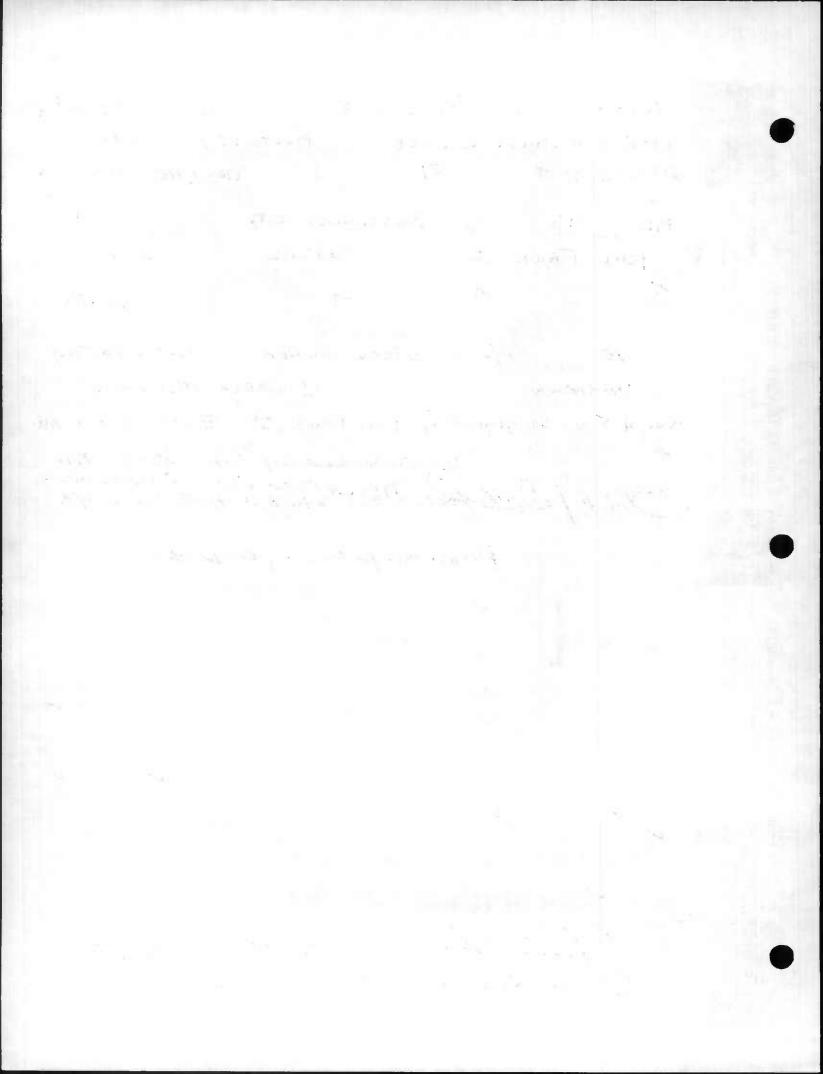
MD21201

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Extan Clinic

h 16 5. (01 ey, Year)

32. Registrar's Signatura

what Taydoon Randall,



98-1166-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene LEONA Certificate of Death PESNELL Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARCH 02, PESNELL EONA 1998 10:51 AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA 3009 GLENDALE AVENUE BALTIMORE 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 10 M 200 F Months Deys Yrs. 505-22-5496 Director MARCH 23, 1918 NEBRASKA Usuel Residenca of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits 7 is marked other than "natural", or fems 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Pres 2 No Director MD NIA BALTIMORE CIT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U. S.A. (FLENDALE 3009 AVE death Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. pernit. Pages 1 end 2 should be filed within 72 hours after to Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any injury or other traumatic event, its Medical Examina 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: þ WHITE 3 Widowed 4 □ Divorced Completed 16a. Decadent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 19+1 HOMEMAKER HOME 2 YRS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) KOBERT EVANS UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) 21234 3009 AVE BALTO, MD REBECCA. C. MCDONALD GLENDALE MRS 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-4-98 BALTO, MD GREENMOUNT 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility HARTLEY MILLER FURERAL 21 Signature of Funeral Service Licenses Reller 21234 Dellas BALTO, - RD MD Harford 7527 23a. Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Fine) CAMIONASCULAR DISEASE Statends Cuenone disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner physicien and the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of) ettending p ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by OF THORT P 24b. Were autopsy lindings eveilable prior to completion of cause of death? 24a. Was en autopsy Completed peeu Disportio has 1 Yes 2 No 1 Was 2 No certificete Division of Vital Atténding Physician: funeral director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Naturei 5 Pending 1 ☐ Yes 2 ☐ No Hopping or Amendi Investigation 2 Accident 6 Could not be 3 Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as steled.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical Within 2 29d, Date signed (Month, Dev. Year) 29b. Signafure and title of certilier 29c. License number Millimie

State Registrar

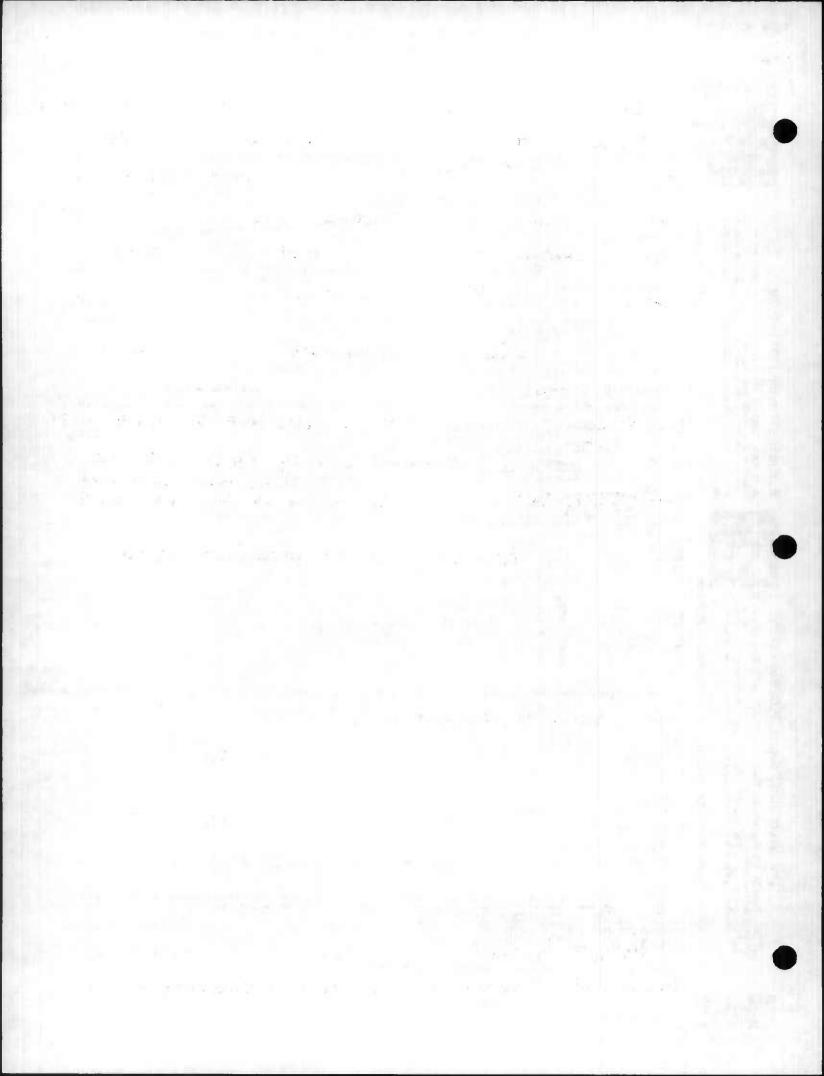
MARGARAS 31. Dete filed (Month, Dey, Year) 4

A. Whow My 111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signature who Davidson-Randall

30. Name and address bl person who completed cause of death (Item 23a) (Type, Print)

OCME

MARCH 02, 1998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1 Decedent's Name (First Middle | est) **Physician** Reeves 4:45P.M. Mae February 7,1998 2 -unic /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner If Under 24 Hrs. 8. Date of Birth (Month, Dey, Rd omose If Under 1 Yaar Birthplace (State or Foreign Country) 5. Social Sacurity Number 6. Sax 7. Age (In yrs. lest birthday) **Funeral** Months 1 M 2 X F Days 244-20-350 Usual Residence of Decedent 2 Yrs Director Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mentel Hygiene. nnt: If flem 27 is marked other than "naturel", or items 23s or 28s-f show 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumetic event, the Madical Examiner must be notified at 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citlzen of What Country? 2113 200 10SE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 12. Was Decedant Evar in U,S Armed Forces? 1 ☐ Yes 2 No If Yes, Giva 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify by 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EMPloyed ea utican 17 Father's Nama (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be BERNAED Smith UICA TORNE - Daughter 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 20b. Place of Disposition (Neme of cematary, crametory or other plece) RANDALISTOWN MD 211 33 1 UIRA other 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If its eny injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Noetol **EMORIA** 22. Name and Address, of Facility 21. Signature of Funeral Service Licensee Homes WEST INC WADASH AUE 4300 21215 al Balto 1 23a Part . Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Carcinomatosis/Abdominal disease or condition resulting in death) months Examiner Due to (or as a consequence of): Examiner Pancreatic Cancer/Metatstatic months physician and the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 98 esn signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings eveilable prior to should l Completed 24a. Was an autopsy performed? completion of cause of death? s certificate has b director, page 2 s 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Attending Physician: funeral director, Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 D Inpatient 2□ ER/Outpatient 3□ DOA Certification: To After this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcida 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 T Homicide

To the Hospital or Attend with 24 hours after deeth To the Funeral Director: A completely filled in by the I

edical

State Registrar 31. Date filed (Month, Day, Year) 4 1938

29a. Certifian

(Check only one)

29b. Signature and title of certifier

Michael J. Schultz, MD 23 Crossraods Dr filed (Month, Day, Year) MAR 0 4 1938 Function Fundament

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the ceuse(s) and mannar as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

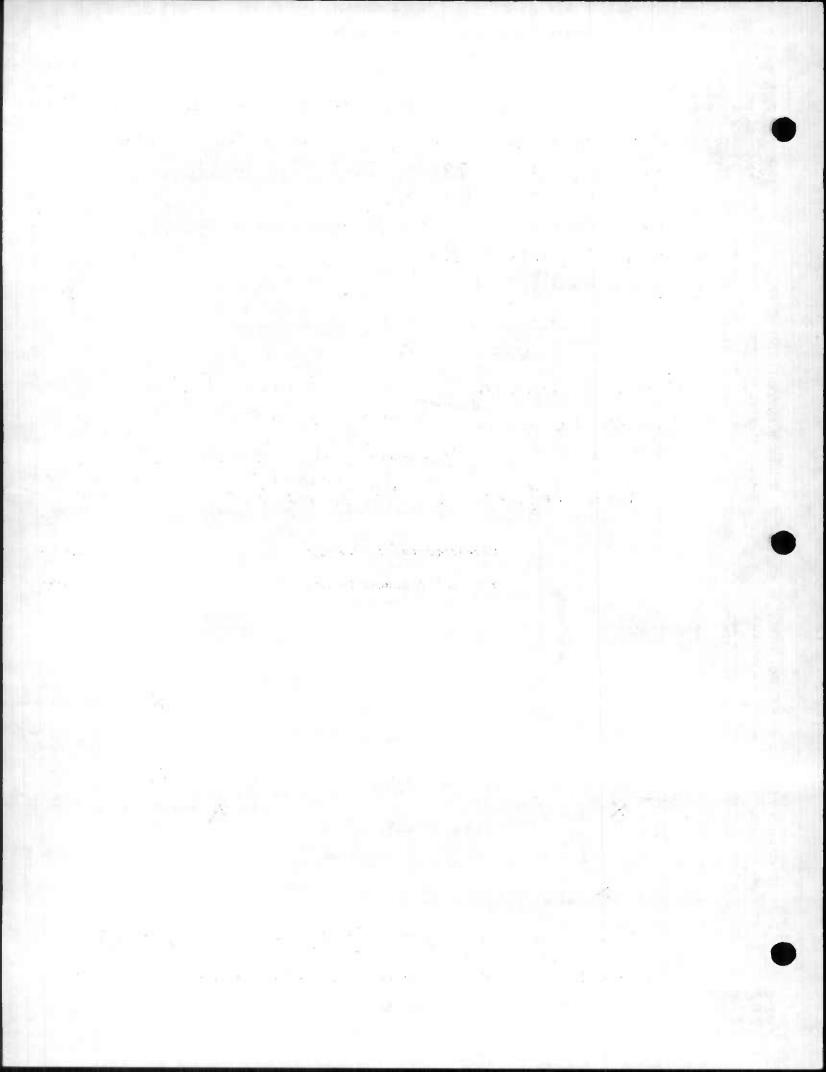
29c. Licansa numbar

#240

29d. Data signed (Month, Day, Year)

21117

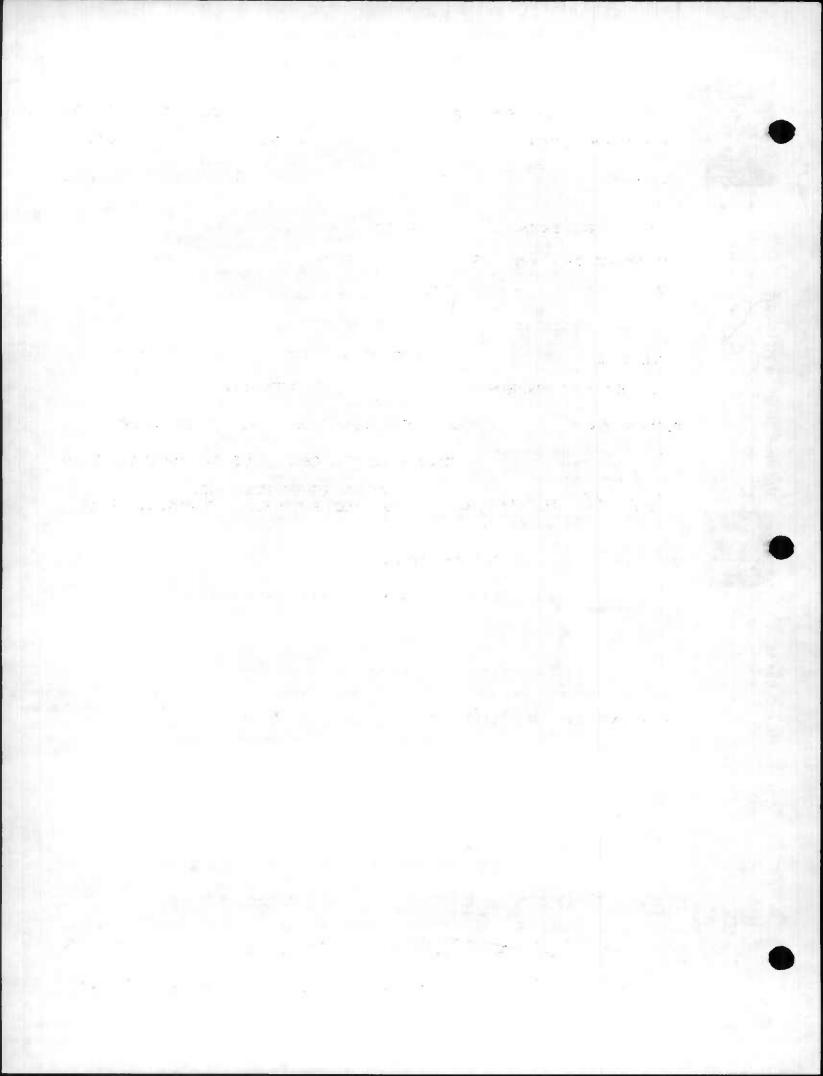
Owings Mills, MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month **Physician** 5:07 A.M. 1998 WILLIAM EMERSON ROBINSON MARCH /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner BALTIMORE TOWSON MANOR CARE TOWSON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours M 20 F Yrs. **Director** 76 7/23/21 MARYLAND 215-18-4187 Usuel Residence of Decedent with the Meryland r 28a-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director TOWSON BALTIMORE MD 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 end 2 should be filed within 72 hours efter death with Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Mod call Examiner must be an once. APT. 503 Funeral 21204 USA 20 DUNVALE ROAD 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Maritel Status Bleck, White, etc. tx Yes 2 No 1941— If Yes, Give Yeer or Detes: 1964 11 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) AIRCRAFT MAINTANCE AIR FORCE 12th GRADE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be THOMAS STEELE ROBINSON ATHA GRAY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BALTIMORE, MD SISTER 8724 ROPER ROAD BETTY R. ADAMS 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Buriel 2 Cremation 3 Removel from Stete 4 □ Donation /5 □ Other (Specify) CROWNSVILLE, MD 3/5/98 CROWNSVILLE VET. CEM. 21. Signature of Funerel Service Licensee 22. Neme end Address of Facility JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON for the following the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, lock, or heart failure. List only one gause on with line. TOWSON, MD 21286 Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical oneum onia Examiner Due to (or es e consequence of): C Examiner hinsons physician and the buriel-trensit requires that the death certificeta be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 50 USB 0 signed by the a d be detached t Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed The law certificate hes t 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 this 27. Mennet of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 5 Pending Investigation or Attending 1 Naturel death. MA 1 ☐ Yes 2 ☐ No 2 Accident after deat Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcide 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or Investigation, In my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. Within To the 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) MO 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 1825 MD York HOU 31. Date filed (Month, Day, Year) 32. Regist Registrar MAR 04



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Items: 23a part I per MEO G-757 3/30/98 dh 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month KENNETH RANGE, SR. FEBRUARY 20, 1998 1430 PM 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **#1 CENTER DRIVE** NORTH EAST CECIL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Deys Hours XXM 2□ F 44 Yrs. 454-94-0320 07/22/1953 TX Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MN RAMSEY VADNAIS HTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3248 BELMAR DRIVE 55127 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 20X Married 1 ☐ Yes 2 XNo Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 TRUCK DRIVER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JESSIE RANGE ATHA GREEN 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBIN RANGE/WIFE 3248 BELMAR DRIVE, VADNAIS HTS., MN 55127 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ELMHURST CEMTERY 2/27/98 ST. PAUL, MN 21. Signature of Funerel Service Licenses 22. Name and Address of Facility STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heert failure. List only one cause on each line. Approximate Interval Betw Onset and Death DIABETIC KETOACIDOSIS Immediate Cause (Final disease or condition resulting in death) Arterioselerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or as a consequence of): Due to (or es e consequence of): Part It. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings evailable prior to completion of ceuse of deeth? 24a. Was an autopsy 1MYes 2□No 1 XYes 2 □ No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 HOther (Specify) AT SCENE

Physician /Medical Examiner

Department of Important: If any Injury or = 0

Physician

/Medical

Examiner

Funeral

Director

reast be notified at

7 is marked other than "natural", or items traumatic event, the Medical Experience in

other !

el Hygiene.

Peges 1 end 2 should be f nent of Health end Mentel 1 ant: If Item 27 Is marked of

Director

Funeral

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filed within 72 hours efter

21215-0020

Baltimore, Maryland

buriel-transit pue physician the defeched s been signed by t 2 should be detect hes certificete director, this funeral After

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital

Division

Physician/Medical by Be Completed 2 27. Manner of Death

Medical

Examiner Certification:

or Attanding Physician: e efter de. N Director: Afte the Funeral

State Registrar

J. Laron Locke M.D. 31. Date filed (Month, Day, Year)
WAR 0 4 1998

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

1XYes 2□ No

1 XNatural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

32 Registrar's Signature

right MD

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28d. Describe how Injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Phyefcfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

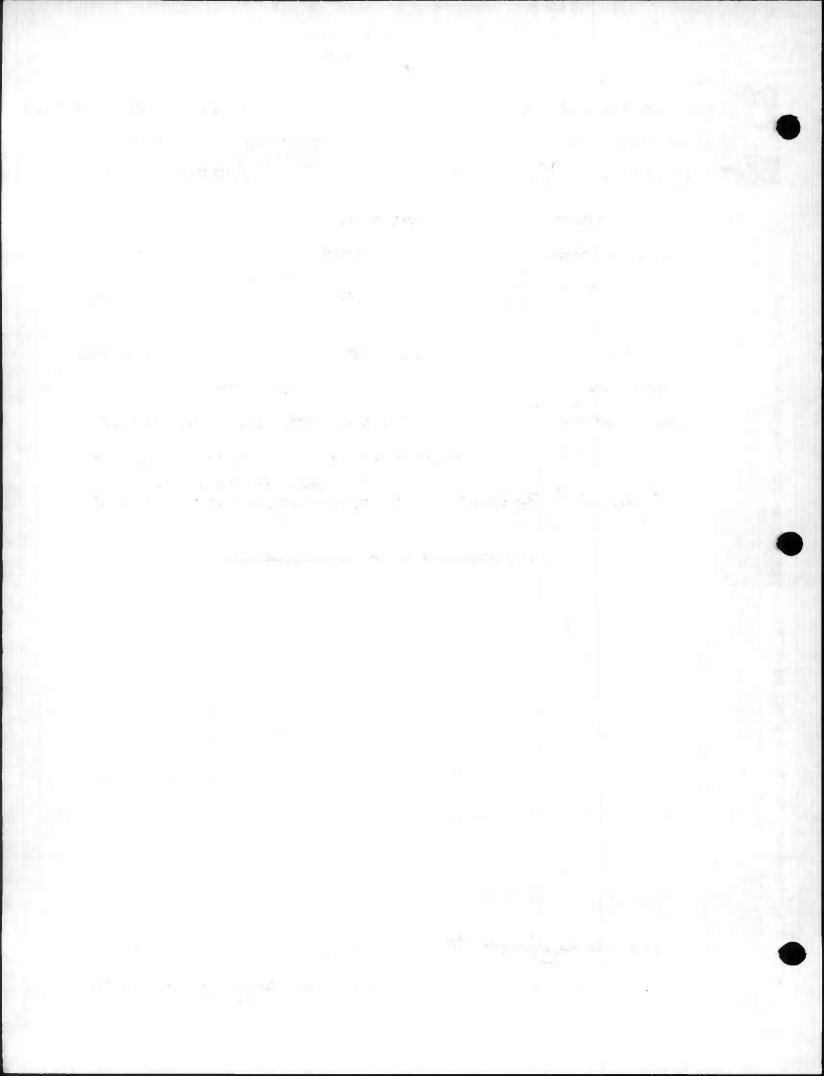
2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

FEBRUARY 21, 1998

111 Penn Street, Baltimore, Maryland 21201

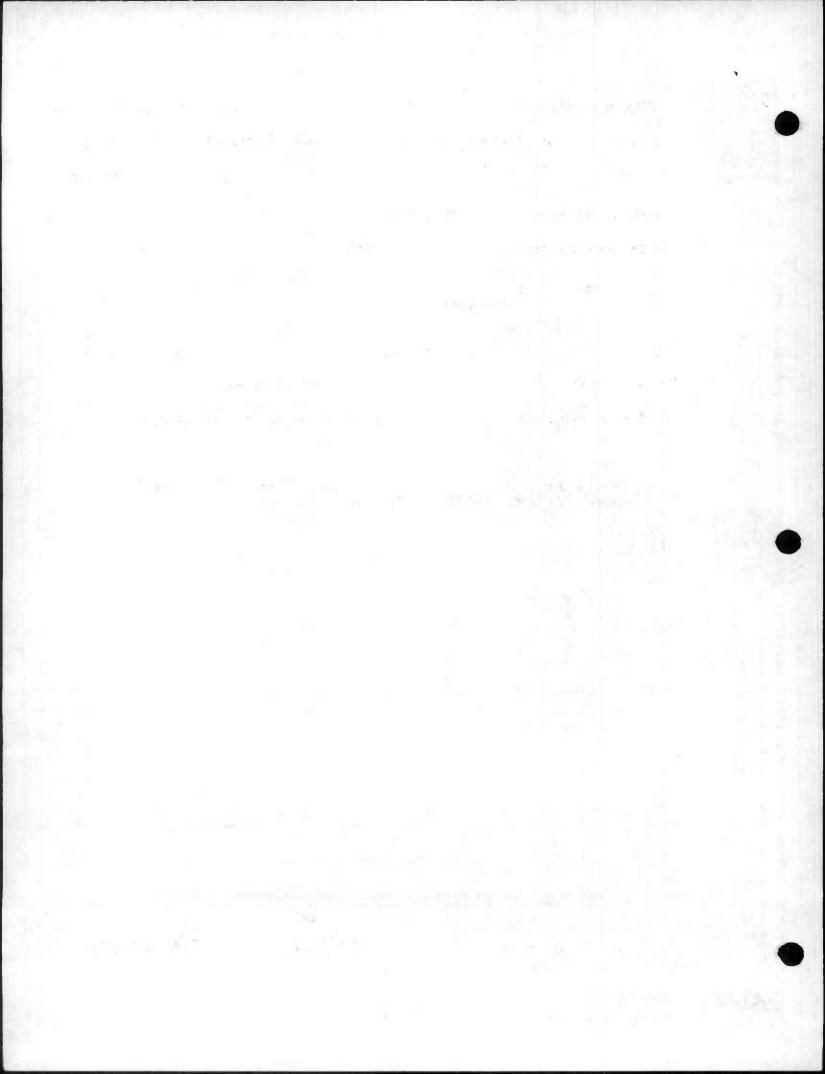
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	•	Ιt	ems: 24a,25,26,29,	State of M 30per M.I	Maryland / De G-757	epartment of l	lealth and Death		rgiene 9	8 06703	3
	Physic		1. Decedent's Name (First, Middla, La Charles He		Rudol	ph		2. Date of De Month	Dev	3. Tim f. Year 998 6 - N	
	/Medi Examii		4a. Facility Name (If not institution, give Lions Manc	e street end numbe	r) .		4b. City, Town, or		h 4c. County		
4	Funerai Director		5. Social Security Number 6. 9 214-05-5813	Sex 7. /	Age (In yrs. last birtho	Months Davs	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, De		9. Birthplace (State or Fo	<i>reig</i> n
	with the Maryland a or 28a-f show the nutfied at	tor	Usual Residence of Decadant 10a. State 10b. County Maryland Alleg	any	10c. City, Town o					10d. Inside City L 1 ☐ Yes 2 §	
	ath with the Marylan 23a or 28a-f show	Funeral Director	10e. Street and Number 514 Patterson A	venue		10f. Zip Code 21502			10g. Citizen of U.S.A.		
020	ours efter des alt, or items Examiner m	by	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Types 2 If Yes, Give Year or Dates	?]No	3. Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 ☐ No	dispanic Orlgin? (Sen, Mexican, Puer Specify:	specify Yes or No to Rican, etc.)	Bla	ce - American Indian, ck, White, etc. v: White	
21215-0020	d within jiene. r than "	Completed	15. Decedent's E (Specify only highest gra Elamantary/Secondary (0-12) 12	ducation ida completed) Collage (1-40)	(G lift	ecedant's Usual Occup ive kind of work done e. DO NOT use retired hanic	during most of wa	rking		usinass/Industry	
Maryland	iges 1 and 2 should be filed it of Health and Mental Hygi If Item 27 Is marked other or other traumatic event, I	To Be (17. Fether's Neme (First, Middle, Lest, Henry Rudolph				18. Mother's Nar Edyth K	me <i>(First, Middle,</i> raus	, Maiden Sumen	ne)	
Mary	2 0 0 0		19a. Informant's Name/Relationship (Hazel L. Rudolph			ailing Address (Street Patterson					
Baltimore,	permit. Pages 1 end Depertment of Health Importent: If Item 27 Any Injury or other tr 2008.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific		20b. Plece of Di	sposition (Neme of crametory or other ple		Date		City or Town, State	
Balt	permit. Pages Depertment of Important: If it any Injury or o		21. Signeture of Funeral Service Licer Ronald S. W.	Made of	18/98	Baltimore.	, Marylar	nd 21201		imore Street	
	Physician /Medicai Examiner	er.	23a. Part 1 Enter the disease, or comshook, or haart failura. List only Immediate Causa (Final disease or condition resulting in death)	e. ADL	Due to (or as a con	Pren	ng, such as cardied		rrest,	Approximete Intarval Between Onset and Deat	n h
x 68760,	the death certificate be executed by the attending physician end ached for use as the buriel-trensit	√Medical Examiner	Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last	b. UUS c. d.	Due to (or as a cons	sequence of):				6 mont	tis
O. Box	the atter thed for n	Physiclan/Me	Part II. Other significant conditions of	ontributing to death	but not rasulting in the	e underlying cause giv	ren In Part I.	23b. Did	tobacco uae co	ntribute to the cause of de	ath?
s, P.O	es thet the de igned by the a be deteched t	by Ph	C.A.D, S/	M.I	, C.D.	P.D.		10	Yes 2≅ No	3 Probably 4 Unk	nown
Records,	aw requires been so should	Completed						24a. Was perfo	an eutopsy rmed?	24b. Wera autopsy findin available prior to completion of cause of death?	_
ital F		Be Cor	25. Was case rafarred to medical				26. Placa of Dea	1 🗆 th (Check only o	Δ1	1 ☐ Yes 2 ☐ No	
	ding Phys h. After this funeral di	Certification: To E	examinar? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		ury 28b. Time	of 28c. Injury	4X_J Nursing H	ome 5 Reside 1	dence 6 Oth		
Divi		Certific	3 Suicide 6 Could not be datermined	Zoe. Piece of it	jury - At homa, farm, tc. <i>(Specify)</i>	street, factory, office		28f. Location (S City or Tox	Straet end Numb vn, Stete)	er or Rural Route Number,	
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edical	29e. Certifier (Check only one) 1 ☐ Certifying Phyone) 1 ☐ Medical Example 1	Iner: On the basis of and menner s	of axaminetion and/or	ath occurred at the tim Investigation, in my o	ne, date and place plnion, daath occu	, and due to the rred at tha tima,	cause(s) and ma data and place,	inner as stated. and due to the ceusa(s)	
	To the within 2 To the comple		29b. Signature end title of certifier V. A. RGW	ithan		29c. License	e number		A	d (Month, Dey, Year)	
	Sta Registr	te	30. Nama and address of person who v. A Ranjithan 31. Date filed (Month, Dey, Year) MAR 0 3 1998	Lions Mar		g Home Set	on Dr.Ex				502

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:20 Am Stator Herbert FEBRUARY 27, 1998 Lee /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner BALTIMORE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 10, 15 Birthplace (State or Foreign Country)
 N C 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 15€M 2□ F 70 Yrs. 239-32-5811 1927 Director Usuel Residence of Decedent the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at N/A BALTO 1 Yes 2 No Director 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number with 3828 REXMERE RD 21218 U.S.A. Funeral death 14. Raca - American Indian, Black, White, etc. 12. Was Decadent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) hours after 1 Yes 2XXIo If Yes, Give Year or Datas: 1 Never Married 2 Married 1 ☐ Yes X No Specify: Specify: BLACK by 3℃ Widowad 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) ifiled within 7 i Hygiena. College (1-4or 5+) Elementery/Secondary (0-12) STEEL CO 7th STEEL WORKER traumatic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental H UNKNOWN STATON JOSEPHINE SHERROD Lo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is m any Injury or other traun once. 9 EVELYN GODSEY 3828 REXMERE RD BALTO, MD 21218 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Bunial 2 Cremation 3 Removal from State DULANEY VALLEY MEM 1998 4 ☐ Donetion /5 ☐ Other (Specify) COCKESVILLE, MD 22. Name and Address of Facility BETTS FUNERAL HOME 21. Signature of Funeral Servica Licansee 1129 N. CAROLINE ST BALTO, MD 21213 allicia 23a. Part 1. Enter the diseasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting in death) Two months nviedical Pulmonary Tuburculosis **Examiner** Due to (or as a consequence of) Physician/Medical Examiner tha deeth certificata be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury Due to (or as e consequenca of) physician and that initiated events resulting in death) Last Due to (or as a consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. ed by the a 23b. Did tobacco use contribute to the cause of death? signed by t 2 No 3 Probably 4 Unknown Clostridium Difficile colitis 1 Yes that þ The law requires 24b. Wera autopsy findings available prior to 24a. Was an autopsy parformed? Completed Ocep Vien Thrombosis completion of causa of death? After this cartificete has Staphylococcal Aureus Preumonia 21 No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) funerel 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Attending 1 Natural 1 Tes 2 No deeth. I or Attendi after deeth. Director: A 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner es steted.

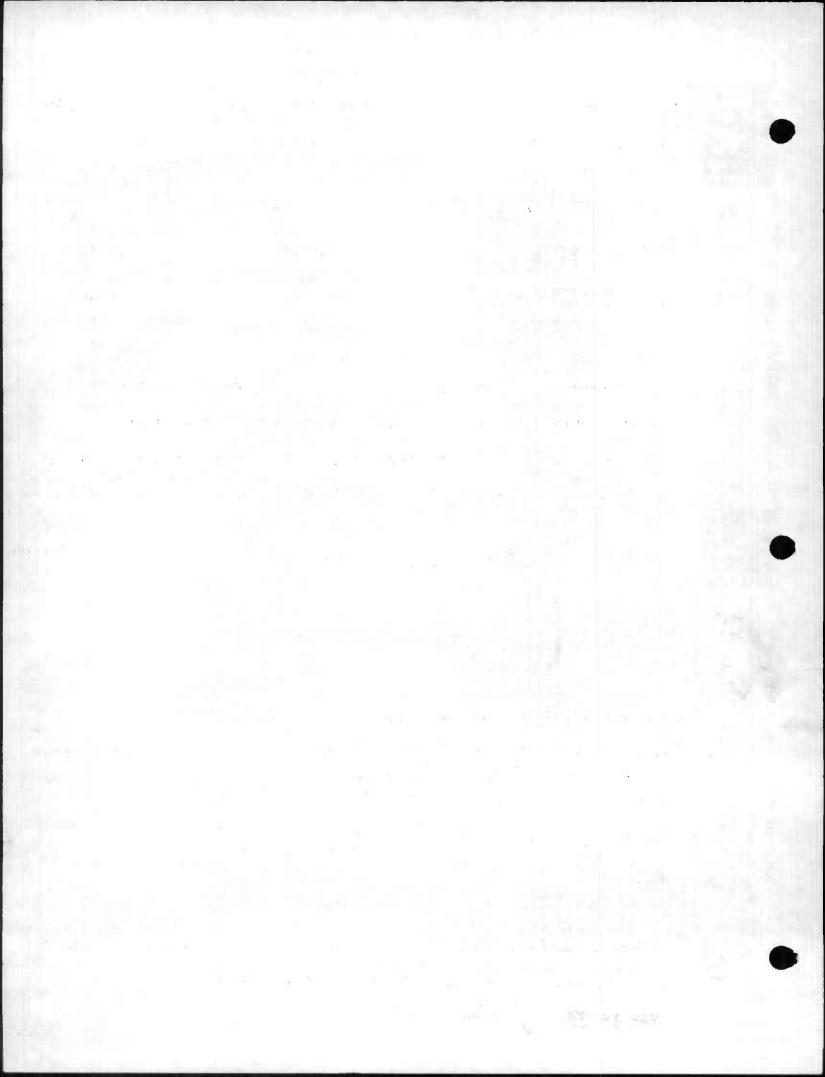
2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mannar stated. edicai 29a. Certifier completaly (Check only one) 29b. Signature and title of cartifier 29c. Licansa number 29d. Date signed (Month, Day, Year) February 27,1998 Warl Kul Res 000 - mo (0) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tower '100 Hopkins Hospital Kanl Kuhn Johns 31. Date filed (Month, Day, Year) 32. Registrar's Signatura

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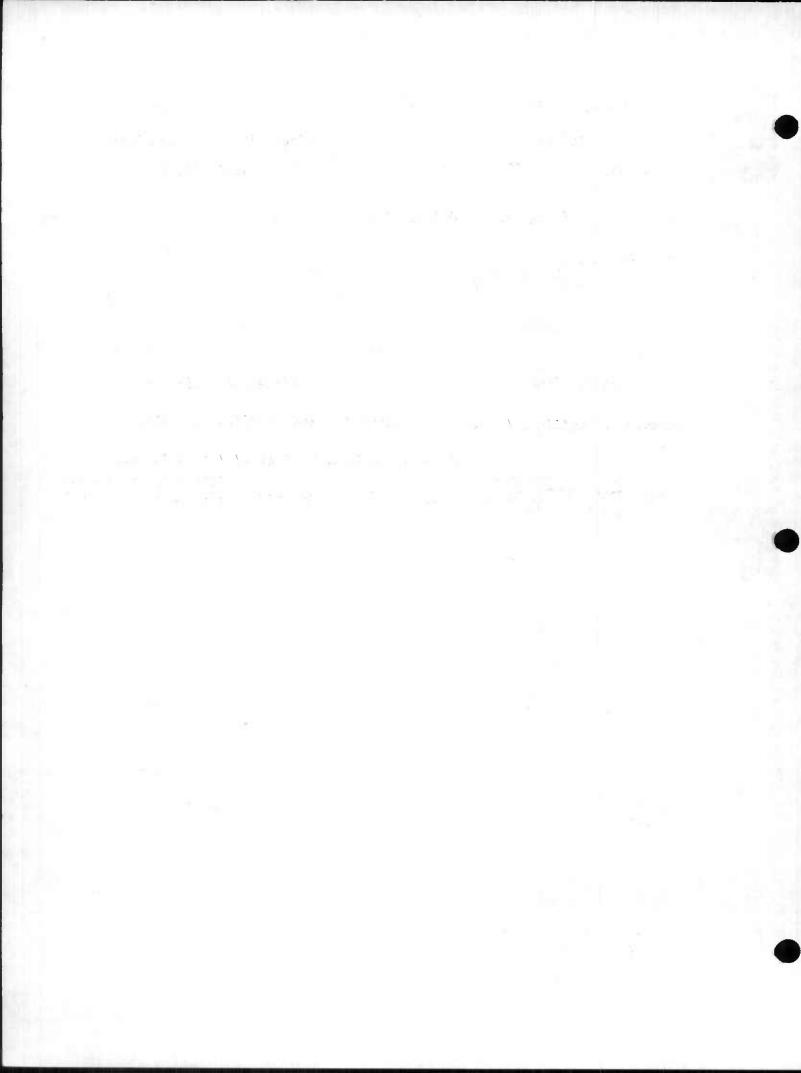
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Physic	cian	Decedant's Neme (First, Middla,	,				Deta of Deet Month	Dey Yeer		
/Med			Elizabeth S	heffield		# 65 Y	March 2	, 1998	8:45am	
Exam	iner	4a. Facility Name (If not institution, 6 Sunset				4b. City, Town, or Lo		4c. County of De		
.				e (In yrs. last birthde	v) If Under 1 Yaar	Owings Ma	8. Date of Birth	Baltimo,		
Funera Directo		216-10-2500 Usuel Residence of Decedent	1□ M 27CXF	77 Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Dey, April 1	1, 1920 N	irthplece (Stete or Foreign Sylintry)	
rland		10a. Stete 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
ter death with the Marylan thems 23a or 28a-1 show	tor	MD Balti	more Co.	Owings 1	lills				1 ☐ Yes 2 No	
th the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Whet C	Country?	
th wit	ain	6 Sunset Rd.			2111	17		USA		
r dea	Funerai	11. Marital Status	12. Wes Decedent I Armed Forceş?	Ever in U,S. 13	. Was Decedent of It It Yes, specify Cub	dispenic Origin? (Spen, Maxican, Puarto	ecify Yes or No- Rican, etc.)	14. Rece - Am Bleck, Wh	nerican Indien, nite, etc.	
urs at	þ	1 ☐ Never Merried 2 ☐ Marria 3 🖾 Widowed 4 ☐ Divorced		ło	1□ Yas 2√2No		7/12/12/	Specify:	rite	
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within 72 ho jiene. r than natur	Completed	Elementery/Secondery (0-12)	College (1-4or 5	+) life	. DO NOT use retire	d)	9			
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d 2 sho th and 7 is me traum		19e. Intorment's Name/Reletionshi						City or Town, Steta,	, Zip Code)	
s 1 and of Haalth itam 27		Bernard E. Shef	field / Son	20b. Plece of Dis	inset Rd.,			20c. Location - City of	or Town, Stata	
		1 1 Burlal 2 □ Cremetion			rematory or other ple					
permit. Pages 1 ar Department of Haa Important: If Itam.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li			Lage Memor			Baltimore,		
P de de la companya d		- The	ROO.					Reisterst		
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/Medical		Immediate Cause (Final disease or condition resulting in death)	e. Co~ >	bue to (or es e cons	Hear + mequence of):	te-12-	2			
ifficate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated avents resulting in death) Lest	c	Due to (or as a cons						
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daath daath	icia	Pert il. Other significant condition	s contributing to death by	ut not resulting in the	underlying cause gi	ven in Pert I.	23b. Did to	bacco use contribu	ite to the cause of death?	
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2 5 5 5	Completed b						24e. Wes a perform		Were eutopsy tindings aveilable prior to completion of cause of deeth?	
The late has page	Con						1 □ Y	as 20No	1 ☐ Yes 2 ☐ No	
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- 5 00	To	1 Yes 2 No	Hospitel: 1 Inpetie		ent 3LI DOA			ence 6 Other (Sp	pecify)	
ath. r: After the funer	ation:	27. Menne of Deeth 1 Naturel 5 Pending 2 Accident investige		y Year) 28b. Time Injury	Wo	ry et rk?] Yes 2 □ No	28d. Describe how Injury occurred			
tal or Attanding Ph rs aftar death. al Diractor: After th led in by the funeral	Certification:	3 Suicide 6 Could no determin		ury - At home, term, c. (Specify)		treat and Number or in, Stete)	Rural Routa Number,			
Hospi 14 hou Funer taly fil	edical		Physician: To the best of caminer: On the bests of end manner ste	examinetion end/or						
To the within 2 To the comple	Me	29b. Signature and title of certitier	\ (1	29c. Lican	sa number	2	9d. Data signed (Mo	nth, Dey, Year)	
		hull		2 1	2 D2	D27123 3/3/1				
6		30. Neme end address of person w		eath (Item 23e) (Typ	e, Print)	Reis	ten Jou	~ (m)	21136	
S	tate	31. Dete tiled (Month, Dey, Year)		ar's Signature						
Regis		MAR 04	1998	the Devident	-Abndello					



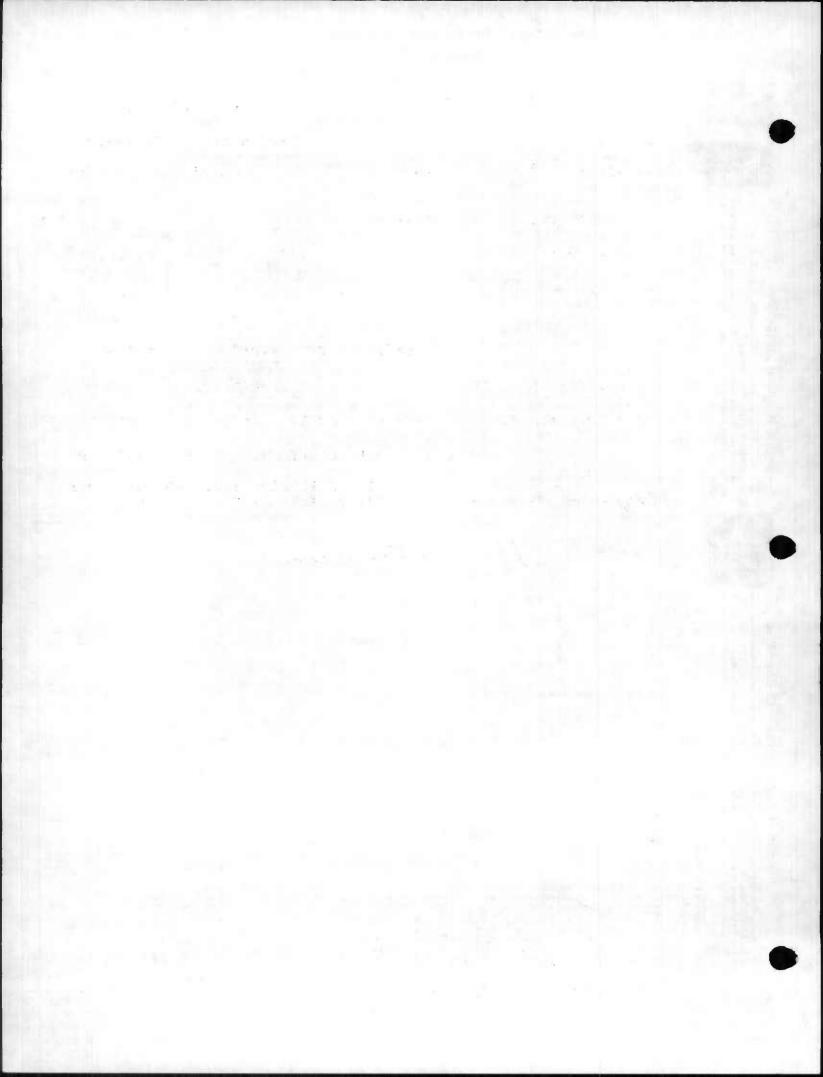
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last)
PASQUALE JOSEPH SPINNATO 2. Dete of Deeth 3. Time of Death F E B **Physician** 25, 1998 1:15 p.m. /Medical 4b. City. Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner 8 DANBEN COURT PERRY HALL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 21. 5. Social Security Number Sex 1⊞M 2□ F 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** Deys MARYLAND 217-52-5996 4 8 Yrs. Director Usuel Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 ☐ No MD BALTIMORE PERRY HALL Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 1 I is marked other than "naturel", or items 23a or traumatic event, the Medical Examiner must be a 8 DANBEN COURT 21236 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours aftar death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a any Injury or other traumatic event, the Modest Examines mass. Funeral 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritel Stefus 1 Yes 2 No
If Yes, Give
Year or Detes: 1 ☐ Never Married X Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE py 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) RESPIRATORY THERAPIST MEDICAL 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) JEROME JOSPEH SPINNATO JOSEPHINE RODA 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) JANICE SPINNATO/WIFE 8 DANBEN COURT BALTIMORE, MARYLAND 21236 20b. Plece of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GREEN MOUNT CEMETERY 2/28/9 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name and Address of Fecility LTLLY & ZEILER, INC. FUNERAL HOMES explict selens EASTERN AVENUE 1901 BALTIMORE, MD 21231 23a Part Enfor the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiretory errest, about, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and s the bunal-trans Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): certificate be axec P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 88 950 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown signed to Division of Vital Records, by 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to Completed completion of ceuse of death? page 2 s has 1 ☐ Yes 2 Û N 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident ector: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide after 6 the Funeral 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner es stated. Medical (Check only one) 2 Modical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, end due to the cause(s) end menner steted. with IT 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c, License number 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) 1/MD-11/HamleTHel 2

Registrar

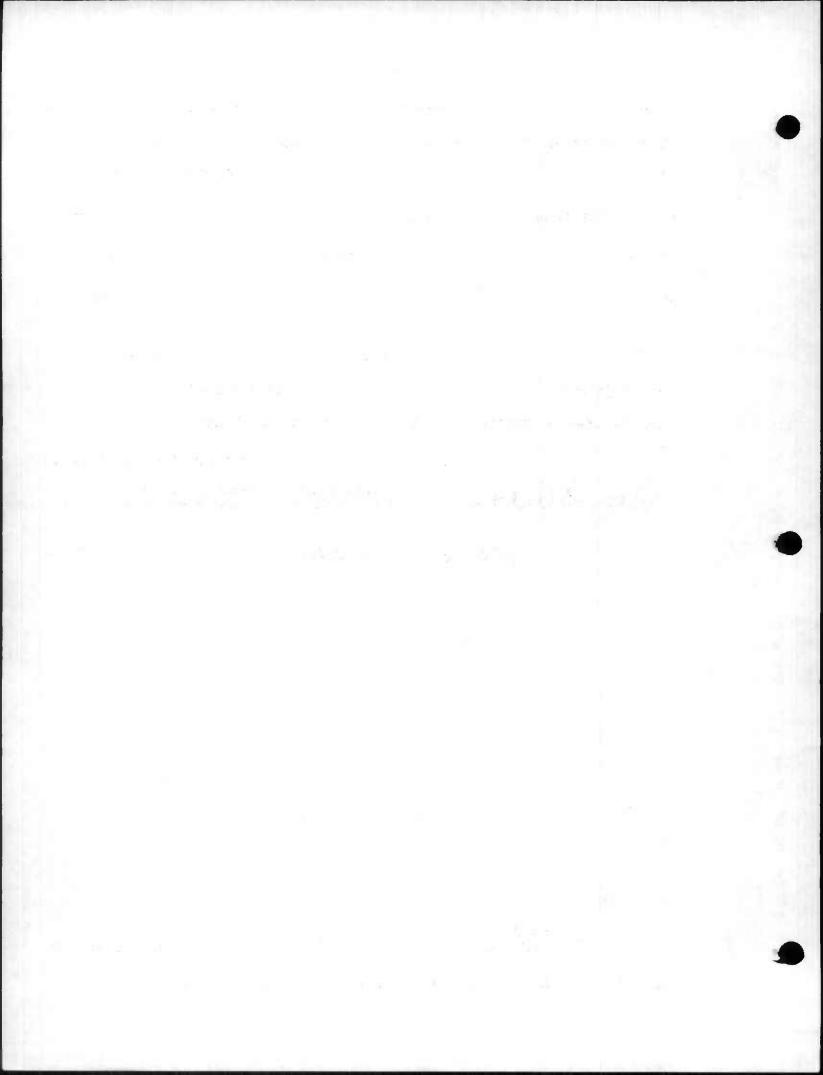
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State of Maryland / Department of Health and Mental Hygiene Q Q

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B	Physic /Medi		Anne	M.	Sc	hepe	r				rch 02	, 1998		9:50PM
	Exami		4e. Facility Nama (If not institution	n, giva straat end num	ber)				4b. City, Tow	n, or Location	of Death	4c. County	of Deeth	
			Dulaney Towson				T #5.		Tows			Balt	imor	e
	Funeral Director		5. Social Sacurity Number 129-34-6324 Usuel Residence of Decedant	6. Sex 1 □ M ŽCXF	'. Aga (In yrs. 87		rs. If Un Mont	hs Days	If Under 2 Hours	Min. (N	ata of Birth fonth, Dey, Y /08/19	(eer) 10	9. Birthp Coun NY	eleca (Stata or Foreign stry)
	land w		10a. Stata 10b. County	,	10c. C	ity, Town	or Location						1	0d. Inside City Limits
	e Man	Director	MD Balt	imore	Т	owso	n							XXYes 2□No
	th with th		10e. Street end Number 111 West Road				10f.	Zip Code 21204	1		10g	j. Citizen of V U	Vhet Coun	
Maryland 21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other treumstic event, the Medical Examinational perporting a once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar XX Widowed 4 ☐ Divorced	If Voc Give	eas?	J,S.		ecedent of hispecify Cub		in? (Specify Y Puerto Rican	as or No- , etc.)	Blac	a - Americ k, White, Whit	
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au	lid be lental ked c	To Be	Josef Znojemsk	8					Mar	ia (Un)	enown)			
ary	shou ind M ind M	-	19e. Informent's Name/Relations			19b.	Meiling Addr	ress (Street		or Rural Rou		City or Town,	Stete, Zip	Code)
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	No. PL		23e. Part1. Enter the disease, o shock, or heert feilure. List	complications that ca	used the daa	th. Do no	ot enter the r	node of dyl	ng, such as c	Ave., (iratory arres	ville.	MU	21228 Approximete
	Physician		SHOOK, OF HEET TENDER. LIST	only one cease on ee	or mie.								1	Intervel Between Onset end Death
	/Medicai		Immediate Cause (Final disease or condition	· AC	IT	ب	ST	RD	KE					1 day
В	Examiner		resulting in death)	0. //			onsequanca					-		/
	P #	ine		- 5										
	icate be executed physician end s the bunal-transit	Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying											
60,	be ey lcian buna		Cause (Disease or Injury	с	_									
68760,	ertificate be executed ing physician end e es the bunal-transit	Medical	thet Initiated events resulting in daeth) Lest	1	a to (or es e consequence of):									
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	death ne atter ed for u	sicie	Pert II. Other significant condition	one contributing to dea	th but not res	sulting in	the underlyin	ng cause giv	ven in Pert I.	2	3b. Did tob	ecco uae cor	ntribute to	the cause of death?
s, P.O	that the death ned by the atter edeteched for u	by Physician/									1 Yes	2□ No	3 Prol	bably 4 Unknown
Vital Records	law requires t as been sign 2 Should be	Completed b							<u> </u>	2	4e. Wes en performe		eve	ere eutopsy findings eilable prior to mpletion of causa deeth?
œ	The ate h	Con									1 🗆 Yes	200No	10	Yes 2 No
ita	Physician: The this certificate and director, page	Be	25. Wes case referred to medica axaminer?						26. Placa	of Death (Che	ck only one)			
of	hysic ldire	L _o	1 Yes 2 No	Hospitel: 1 🗆 In	patient 2	ER/Outp	petient 3	DOA Oth	ner: 4 Nur	sing Home 5	Residen	ce 6 Oth	er (Specif)	y)
sion	anding Phanth.		27. Menner of Deeth 1 Natural 5 Pendir 2 Accidant invasti	28e. Dete of (Month)	Injury Dey Year)	28b. Ti	me of jury M	28c. Inju Wo	ryet rk? ∣Yes 2 ☐ N		escribe how	Injury occurr	ed	
Divis	or where appropriate on Porector of in by the	Certification:	3 Suicide 6 Could determ	nined 28a. Placa c	f Injury - At h g, etc. (Speci		m, street, fec	tory, office			ocation (Stre ity or Town,		er or Rure	ol Route Number,
1	Adept Person	edicai C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the b Examiner: On the bas end menne	is of examina	wledge, ation end	deeth occurr or investiget	ed et the ti	me, dete end opinion, deeth	plece, end du n occurred et t	ue to the ceu the time, dete	se(s) end me e end plece, o	nner es st and due to	teted. the cause(s)
-	To the comp	Me	29b. Signetura and titla of certifie	01				29c, Licens			290	. Date signed	i (Month,	Dey, Year)
			> OHC	orked	Tr.		,	D-10	2840	7	M	arch 3	, 199	98
		ĺ	30. Name and address of person					. 111	m	- MT	. 210	0.6		
	Cto	to	A.H. Ghiladi 31. Dete filed (Month, Dey, Year)					e III	, Tows	son, MI	212	U4		
	Sta Registr	-	MAR 0 4 199	PL . 2. 1	Julian's Sign	- Jane	tall							



Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Important: if item 27 is marked other than "natural," or items 23e or 28a-f show any injury or other traumatic event, the Medical Examinating must be notified at any injury or other traumatic event, the Medical Examination must be notified at any once.

Physician /Medicai Examiner

To the Hospital or Atlanding Physician: The law requires that the death certificete be axecuted within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, paga 2 should be deteched for use es the burial-transit

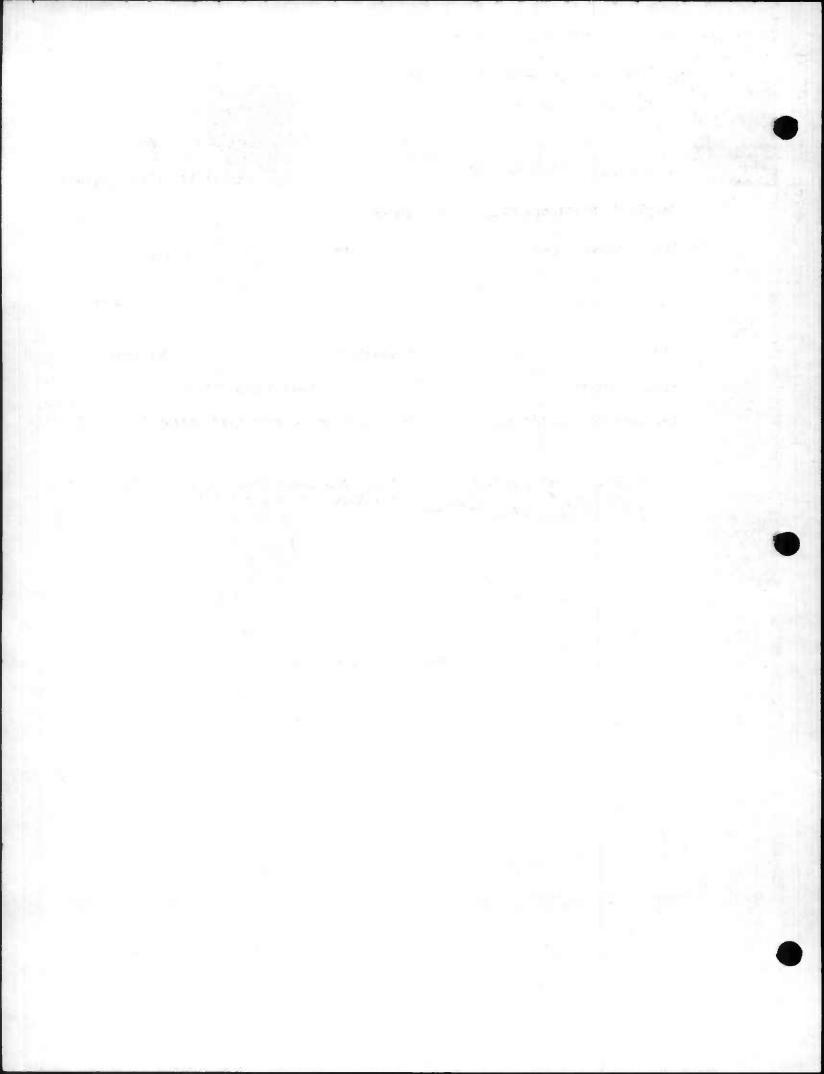
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Please Type or Prin	t in Black Indelible Ink.	Assure All Copies	Are Legible
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by Funeral Director	Isuei Residence of Decedent Oe. Stete 10b. County	e street end number) Act of Balfa ex 7. Age (In yr. 80		day) If Under 1 Year Months Days	4b. City, Town, or L Balhmo If Under 24 Hrs. Hours Min.	me City	7.	Yeer 1998 of Deeth	3. Time of Death				
by Funeral Director	Since Hospia Sociel Security Number 213-20-2693 Suel Residence of Decedent Oe. Stete Maryland Baltim Oe. Street end Number 215 Wendover Ros	#al of Balts ex 7. Age (In you 0 M 2只F 80	Yrs	day) If Under 1 Year Months Days	Baltimo If Under 24 Hrs.	ocation of Deeth	7 7						
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by Funeral Director	Sociel Security Number 213-20-2693 Isuei Residence of Decedent Oe. Stete 10b. County Maryland Baltim Oe. Street end Number 215 Wendover Rose	ex 7. Age (In yra 80 80 10c. C	Yrs City, Town o	day) if Under 1 Year Months Days s.			11/17						
by Funeral Director	Usual Residence of Decedent Oe. Stee 10b. County Maryland Baltim Oe. Street end Number 215 Wendover Ros	10c. C	City, Town o	s.	Trous Intiti.	8. Date of Birt (Month, Da)	h Yeer)	9. Birthpla	ce (Stete or Fore				
by Funeral Director	Oe. Steet 10b. County Maryland Baltim Oe. Street end Number 215 Wendover Ro			or Location			12, 191		,,				
by Funeral Director	Maryland Baltim Oe. Street end Number 215 Wendover Ro			Location			,		d. inside City Lim				
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þ	4.44-0-1-0-1	ad		21218			U.S.A.	Wilet Countr	y r				
by	1 Maritel Status	12. Wes Decedent Ever in	U.S.	13. Was Decedent of H	lispanic Origin? (Sr	pecify Yes or No-		e - America	n Indien.				
	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cubi	en, Mexicen, Puerto	Rican, etc.)	c.						
ם ו	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify	White	5				
9	15. Decedent's Ed	lucation	16a. De	ecedent's Usuel Occup	etion	1.1==	16b. Kind of B	usiness/Indu	stry				
Completed	(Specify only highest gre Elementary/Secondery (0-12)	College (1-4or 5+)	- (G	Give kind of work done fe. DO NOT use retired	during most of world)	king							
00	12	4	H	omemaker			0wn	Home					
8 17	7. Fether's Neme (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Meiden Suman	10)					
2	Purdon Wright				Lucy Agr								
1:	9e. Informant's Name/Relationship			feiling Address (Street									
	Kathleen Kaminsk			29 Sherwoo	d Forrest				-				
20	0e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removel from State	cemetery,	isposition (Neme of cremetory or other plea	00)	Dete	20c. Location	· City or Tow	n, Stete				
	21. Signeture of Tarillo S. Wate, Director 22. Neme and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part. Enter the disease, or complications the Leaused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth												
In di re	mmediete Ceuse (Final lisease or condition esulting In deeth)	е.	Coron	ary arter	diseas	6			UNKNOW				
Examiner ≥ ≖ ∞	•	b	Penp.	nsequence of): heral vasc	cular a	esease			Unlando				
Exa	sequentially list conditions, eny, leeding to immediate ause. Enter Underlying	Due to	(or es e con	sequence of): Stage re		,							
th C	det initieted events	C. Due to /		Stage no	nal di	sease		1	MICHOU				
Medi	esulting In deeth) Lest		41	lension					unknou				
Physician/Me				,									
ly P	ert II. Other significant conditions co	ontributing to death but not re	sulting in th	e underlying ceuse giv	ren In Part I.	23b. Did t		ntribute to t 3 ☐ Proba	he caues of dea bly 4 1/Unkn				
by P						10	108 2LINO	3 - 1000	No April				
Completed b							en eutopsy med?	com	e eutopsy finding eble prior to pletion of cause eeth?				
mo.						1 🗆 Y	es Al No	1 🗆	Yes 20 No				
	5. Wes cese referred to medical				26. Place of Dea	th (Check only o							
5	examiner? 1 ☐ Yes 2 No	Hospitei: 1 Anpatient 2	☐ ER/Outpe	etient 3 DOA Oth	er: 4 Nursing H	ome 5 Resid	lence 6 🗆 Oth	er (Specity)					
inojie	7. Manner of Deeth 1 Natural 5 Pending 2 Accident Investigation	28e. Dete of Injury (Month, Dey Year)	28b. Tim Inju		28d. Describe h	ne 5 Residence 6 Other (Specify) 8d. Describe how injury occurred							
Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At in building, etc. (Special Special S	home, ferm	, street, fectory, office	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)								
edical adical	9a. Certifier (Check only one) 1 Certifying Phy Medical Exam	ysician: To the best of my kn iner: On the bests of examin end manner stated.	nowledge, de netion and/o	eeth occurred et the tin r Investigetion, in my o	ne, dete end piece, pinion, deeth occur	and due to the cred et the time,	ceuse(s) end me dete end place,	enner es ste and due to t	ed. ne ceuse(s)				
	9b. Signature end title of certifier Nambi Sc	reus m)		29c. Licens	e number 2321 HB9	517	29d. Dete signe Februar		ey, Year) 2 1998				
30	D. Neme end eddress of person who de ARSH(2	completed ceuse of death (Ite BAINS, MD SINCE 32, Registrar's Sign Julia Sainda	i He	pe, Print)			-, .						

Registrar DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 1045 P.M Calvin Thompson Owen 2 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Parker 7. Aga (In yrs. lest birthday) 7. Aga (In yrs. lest birthday) 1. Aga (In yrs. lest birthday) ANNE Avundel AVR. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 12 M 2 F 219-32-2087 Director Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYas 2 No ANNE Arundel Md HNNA Polis Director 10e. Street and Number 10g. Citizen of What Country? 208 AVe, permit. Ragas 1 and 2 should be filed within 72 hours after death v. Department of Haelih and Mental Hygiena. Important: If item 22 is marked other than "natural", or itema 23a and Injury or other traumatic event, the Medical Expriner mass once. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Biack, White, etc. 1 Navar Married 2 Married 1□ Yes 2□No Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highest grada completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) 45515 TANCE FUNEVAL Home 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middla, Last) Be Albert OWENS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 208 PARKER Ave. MD. 21401 DONNA Thompson - WIFE ANN A Polis 20b. Placa of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriai 2 Cremation 3 Removal from State Owens Ville, Md. CHEN CEMETERY 2/25/98 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Fecility IVE ANNAPOLIS 21. Signatura of Funarai Sarvica Licensae 23a. Part 1. Errier tha disease, or complications that caused the death. Do not enter the moda of dylng, such as cardiac or respiratory arrast, strack, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Dua to (or as a consaquenca of): 23b. Dfd tobacco usa contribute to the cause of death? Pert Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examinar? Be 26. Place of Death (Check only one) Hospitel: Other: 4□ Nursing Home 5 Residanca 6 □ Othar (Specify) 0 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. injury at Work?

Sician and Durial-transit Division of Vital Records, P.O. Box 68760, ii or Attending P s efter daath. ii Director: Aftar

K is merked other than "natural", or items 23s or 28s-f show traumstic event, tre Medical Expresser mant be nothed at

Saltimore, Maryland 21215-0020

Certification: 1 Natural 2 Accident 3 ☐ Suicide

29a. Certifier

(Check only one)

5 Pending investigation 6 Could not be determined 4 Homicide

28e. Pleca of fnjury - At home, farm, street, factory, offica building, etc. (Specify)

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of cartifier

29c. Licensa number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

MAR 0 4 1998

+ Petersan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert T. Paterson

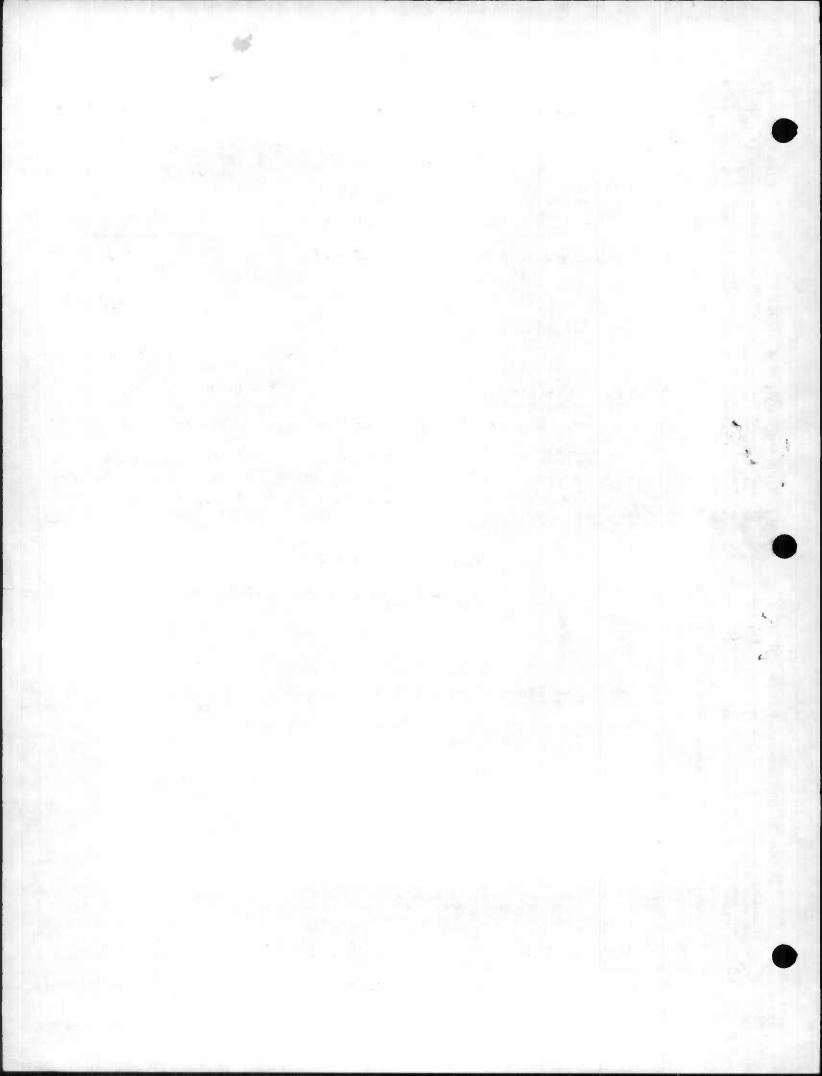
Annapolis md 21401

State Registrar

Medical

600 Ritgely Avenue 32. Registrar's Signature while widson Pandall

To the Hospital within 24 hours e To the Funeral C Hospital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Death Day 26, 1998 Month KOY February 1UCKER 09:30AM 4a. Facility Name (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Perry Point (Month, Day, Yaar) | Hours | Min. (Month, Day, Yaar) VA Maryland Health Care System 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) n⊠M 2□F PEONSYLVANIA Yrs. 0881,8,230 184 18 1162 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No HARFORD WEATERD FOREST HILL 10e, Street and Number 10g. Citizen of What Country? SOAD 9P18 U.S.A 21020 Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 18 Yes 2 □ No it Yes, Give Year or Dales: ₩.₩.∏ 1 ☐ Never Married 253 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5+) BOORDY VINEYARD 8 YRS FOREMA 17. Fether's Name (First, Middle, Lest) 18. Mother's Nama (First, Middla, Maidan Sumama) 314234 1 UCKER LORA ALICE FIKE 19b. Mailing Addrass (Street and Numbar or Rural Routa Numbar, City or Town, Steta, Zip Coda) 21084 19a. Informant's Name/Relationship (Typa, Print) 1. BURKINS 3800 RUSH IZEEKZY (, JARRETTSVILLE 1 JARYLAND 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Locetion - City or Town, State MARCH 2 1⊠ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) BULAIR [ARYLAND amorial 21. Signature of Funeral Service Licensee EVAN FURRALLHAPEL-BELRIR, P.A 22. Name and Address of Fecility FORZAT HILL 3 NEWPORT ORIVE JARYLAND 100 23a. Part 1. Enter the disease, or complications has caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailura. List only one cause on each line. Approximate Interval Betw Immediate Cause (Finel disaasa or condition resulting in death) a Renal failure four weeks Due to (or as a consequence ot):

Physician /Medical Examiner

the

been signed by the atter

this certificate has

funeral

filled in by the

I or Attending Physician: offer death.

Director: After this certifications

To the Hospital o within 24 hours of To the Funeral D completely filled i

Physician

/Medical

Examiner

10e. State

Funeral

Director

Show

ral", or items 23a or 28a-f show

other traumatic event, the Medical

marked other than

Department of Health e Important: If item 27 la sny Injury or other tra

Hygiene.

1 end 2 should be 1 Health end Mental

Peges

Director

Funeral

Completed by

Be

the Maryland

filed within 72 hours after death with

TO PHYSICIAN: ROY TUCKER

Maryland

Baltimore,

KNOWN

NAME

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last

29b. Signeture and title of certifier

30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print)

Diabetes mellitus

Dua to (or as a consequence of): End stage cardiomyopathy Due to (or as a consequence of):

29d. Date signed (Month, Day, Yaar)

February 26, 1998

twenty year:

ten years

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐XNo 3 Probably 4 Unknown Hypertension by Be Completed 24b. Wera autopsy tindings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 2 ☐ No 25. Was cese retarred to medicel examiner? 26. Place of Death (Check only ona) 10 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. injury at Work? 5 Panding Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At homa, tarm, street, tactory, office building, etc. (Spacify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 - Homicida 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and mannar as stated. Medicai 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar statad.

29c. License number

D16608

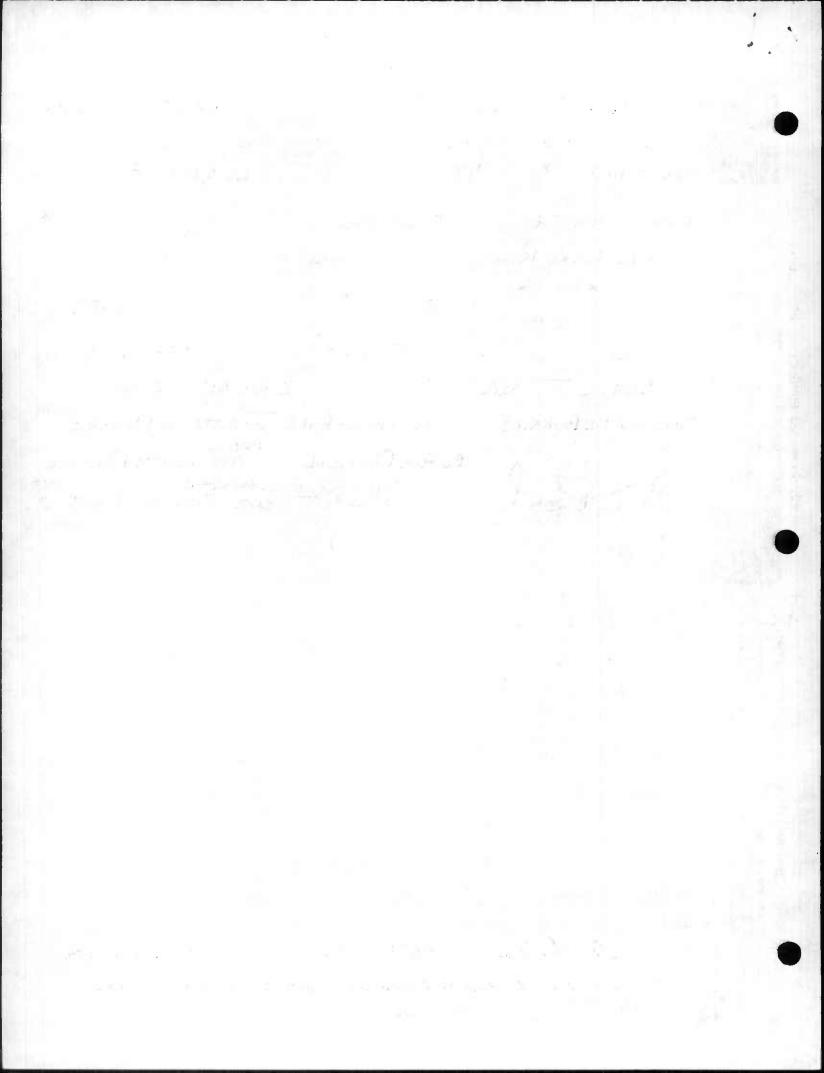
Division of Vital Records, P.O. Box 68769.

The law requires that the death certificate be

State Registrar

KAM KEN LEUNG, M.D., VA Maryland Health Care System, Perry Point, MD 21902 33. Registrar's Signature

in

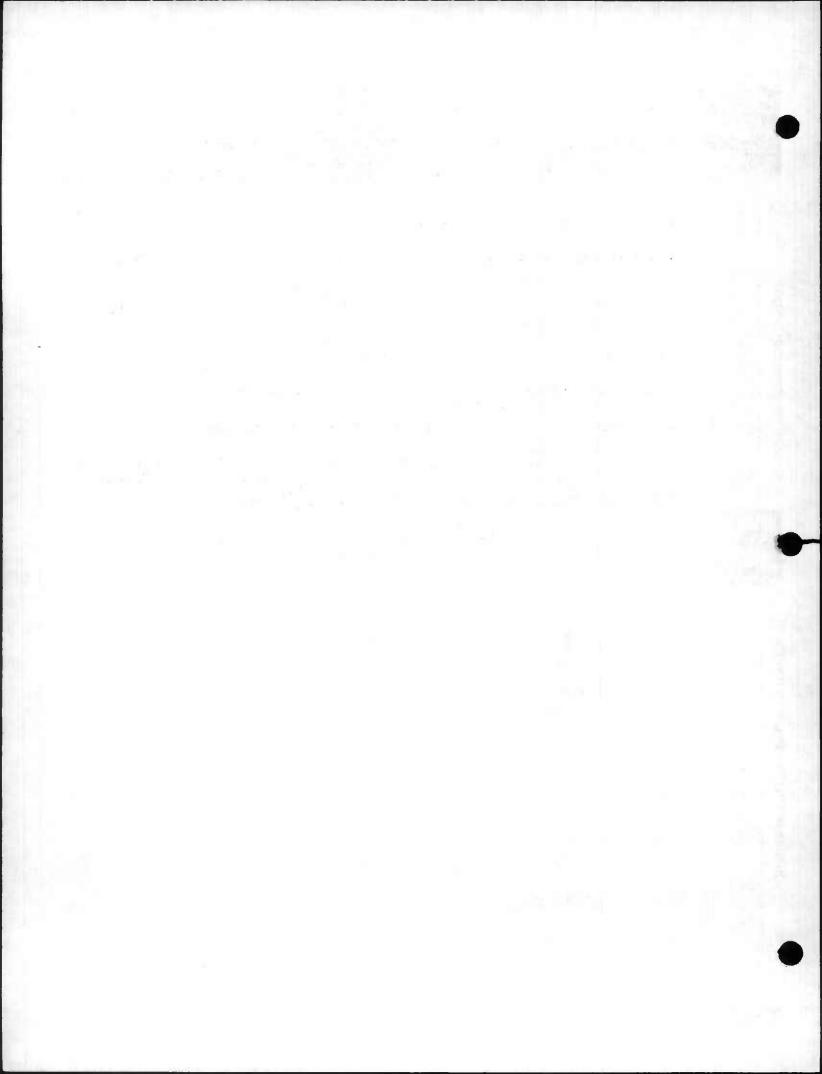


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month Year James 7:10 AM Edward Tatum MARCH 1998 /Medicai 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris at Mercy Baltimore n/a if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funerai** 1**X** M 2□ F Months Yrs. 46 Director 214-58-6439 Aug 15, 1951 Maryland Usuel Residence of Decedent the Merylend 10a. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow r than "natural", or items 23s or 28s-f show the Moucal Examiner must be notified at 1 X Yes 2 □ No Director n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1914 West Franklin Street 21223 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, spacify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 72 hours efter 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 Divorced Specify: Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. 10th Grade d 2 should be filed w th end Mental Hygier 7 is marked other th Carpenter Union Local 538 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be permit. Peges 1 end 2 should be Department of Health end Mental Important: If Nem 27 is marked c any liqury or other traumatic ev-James Soloman Tatum Jean Towns 19a. Informent's Name/Reletionship (Type, Print) brother 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Tatum 1 Beacon Hill Road Baltimore, MD 21207 Baltimore, 20a. Method of Disposition
1 ☑Buriel 2 ☐ Cremetion 3 ☐ Removal from State 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park Mar 5th Baltimore County, MD 21. Signeture of Funeral Security Diverses 22. Name and Address of Facility Nutter Funeral Homes, Inc 2501 Gwynns Falls Pkwy Baltimore, MD 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one ceuse on each light Approximate Intervel Between Onset end Deeth **Physician** /Medical immediete Ceuse (Final diseese or condition resulting in deeth) Value Infection Aurtie Bioprostletia 5 mos. Examiner Due to (or es e consequence of) Smeptococcus Endo carditis 5 mos Vividans Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Intravenous Asuse Dus UNKNOWN Box 6876 Physician/Medical Due to (or es a consequence of): The law requires that the deeth certificate signed by the e Pert II. Other eignifficant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 □ Yee 2 No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy peeu hes certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: T s efter death. I Director: After this certifical Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) STELLA MARIS AT MERCY Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE ၉ 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. tnjury et Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide • Funeral C Hospital edicai KC Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier (Check only one) within 2 To the 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Dano MA 040480 marsh 2, 1998 30. Neme end eddress of person who completed cause of deeth (ttem 23e) (Type, Print) 7672 relain na Fereno, mo Bulto 21236 FERMANDO 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State

Registrar

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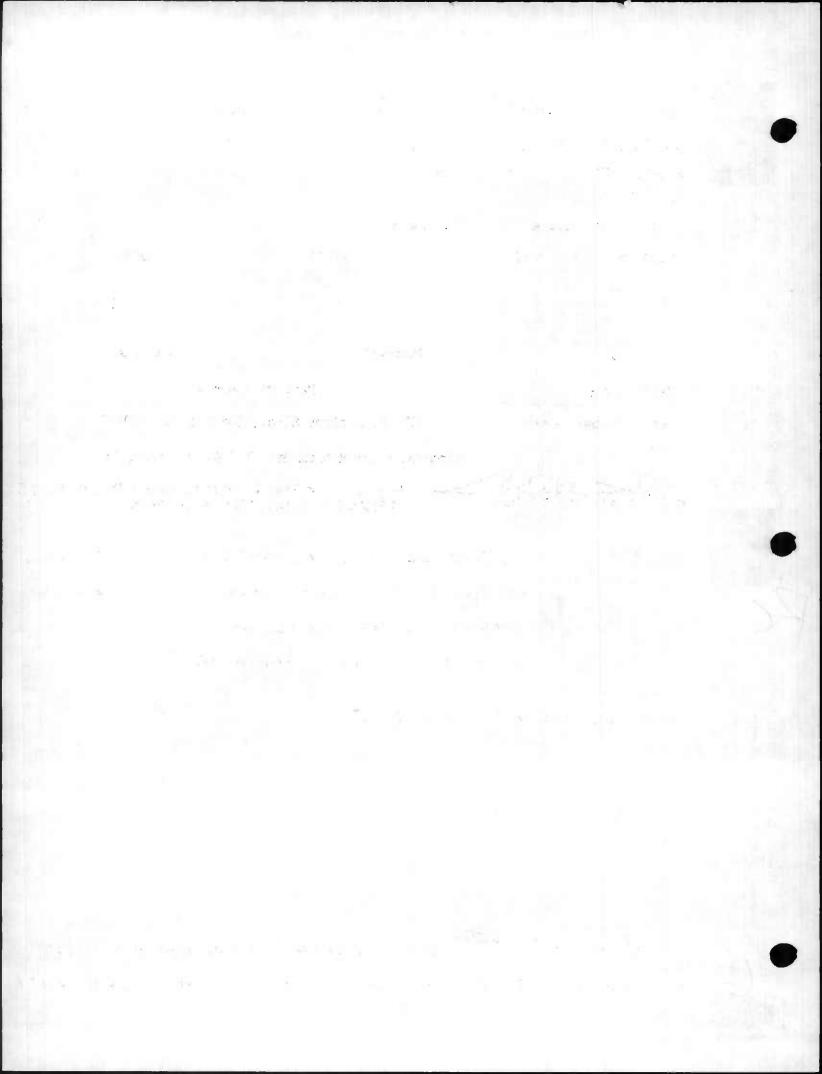
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Dey Vinson Harr February 25, 1998 /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street end number) 4b, City, Town, or Location of Deeth Examiner Ho Baltimore okins toSpita, Johns If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** Months Deys ₩ 20 F 219-38-9958 57 Yrs. **Director** OCT. 31,1940 GEORGIA Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits Yes 2□No Director BALTIMORE CITY MARYLAND N/A 10e. Street end Number 10a. Citizen of Whet Country? 10f. Zip Code 2508 E. FEDERAL STREET 21213 U.S.A. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No if Yes, GiveX Yeer or Dates: 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced NEGRO by Specify: 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 7TH N/A CARPENTER CONSTRUCTION 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be HARRY VINSON ROSE. HUNTER 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Haalth an Important: if itam 27 is any injury or other trau CARRIE LEMON / FRIEND 2508 E. FEDERAL STREET BALTO, MD. 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) ZION CEMETERY FEB. 28, 1998 BALTO, MD. 22. Name end Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME 21213 Approximete Intervel Between Onset and Death E. PRESTON ST. BALTO, mode of dying, such as cerdiac or respiratory errest. Pert1. Enter the diseese, or complications that cause of the shock, or heart feilure. List only one cause on each **Physician** /Medical Immediate Ceuse (Final days diseese or condition resulting in deeth) brain Examiner Sequentially list conditions, it eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Bronchospasm Physician/Medical Due to (or es a consequence of) Obstructive pulmonary Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1□ Yes 2 No 1 ☐ Yes 2 (No 25. Wes cese referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospitel: 1 Lapatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident

Examiner P.O. Box 68760 8 Records. certificate Vital Division of 2 After or Attending Hospital

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72 hours after

Baltimore, Maryland 21215-0020

28a-f show

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"natural", or

Pages 1 and 2 should be filed within 1ent of Haaith and Mental Hygiene. Int: If Itam 27 is marked other than "...

traumatic event, the Medical Examiner must be notified at

Certification: To

after death To the Hospital within 24 hours a To the Funeral C Medical

Registrar

3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Street, Bultimore Maryland, 21287 North Wolfe 31. Dete filed (Month, Dey, Year)

MAR 0 4 1998

32. Registrar's Signature

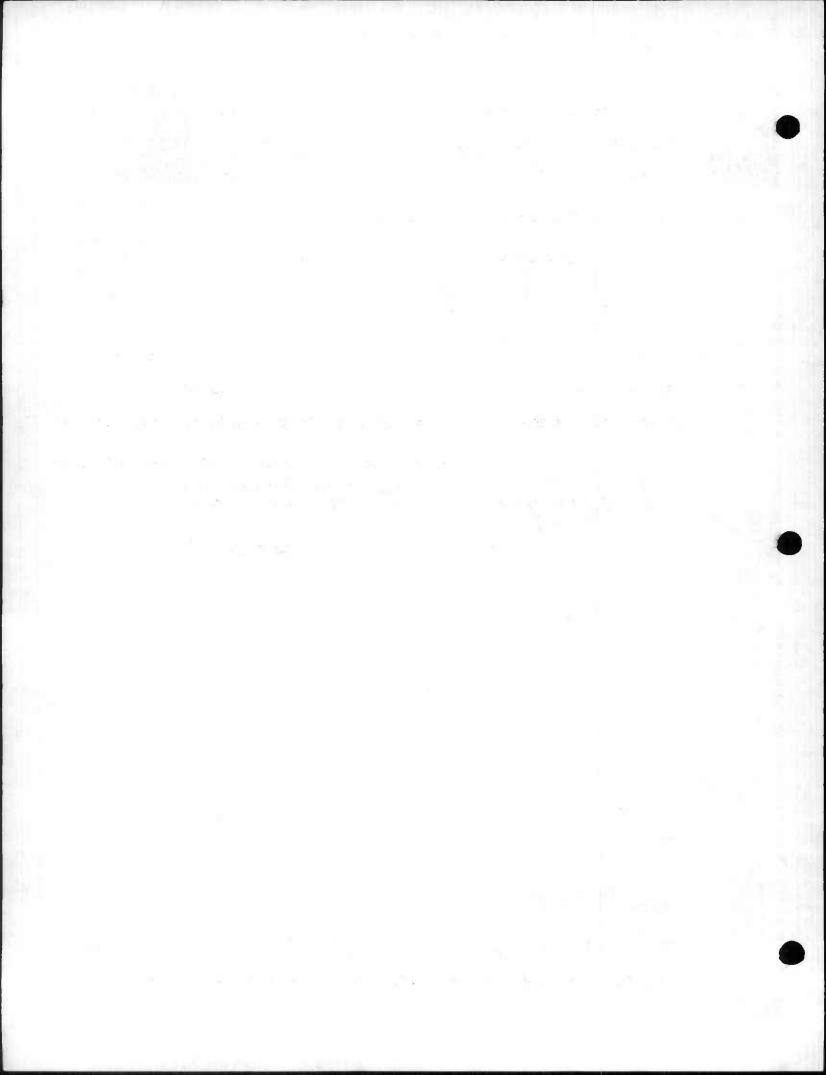
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Physic: /Medi		Decedent's Name (First, Middle, Le CARLO ARM			400			2. Date of Dea Month MARCH 2	Day	Yaar	Time of Death	
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	the 28s	Director	10e. Street and Number]	10f.	Zip Code		1	0g. Citizen of \	What Country?		
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	death ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.				pecify Yes or No-		e - American I		
020	72 hours effer death with the Maryland natural; or items 23a or 28a-f show dical Examiner must be notified at	by	1 Navar Married 2 Married 3 Widowed 4 Divorced	Armed Forcas 1√2Yes 2 ☐ If Yes, Give Year or Dates:	No 1971		specify Cub	Hispanic Origin? (S an, Mexicen, Puert Specity:	o Ricen, atc.)	Bla	ck, White, etc. V: WHITE		
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Division	Attending Phir death.	Certification:	27. Mannar of Death 1 KMatural 5 ☐ Pending 2 ☐ Accident investigation		lry Year) 28b	Time of Injury M	28c. inju Wo 1 □	ryat rk? ∣Yes 2 ∐ No	28d. Dascribe how injury occurred		red		
DIX	1 4 4 E		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	building, e	c. (Specify)	farm, street, fac			28f. Location (Si City or Town	n, State)			
	he Hospital in 24 hours a he Funeral Dietely filled	edicai	29a. Certifier (Check only one)	yalclan: To the best niner: On the basis of end manner st	r examination a	ge, death occurr and/or investigat	red at the ti	me, date end place opinion, death occu	, and due to the c rred at the time, d	ause(s) and ma ate and place,	anner as stated and due to the	cause(s)	
15	Toth	Σ	29b. Signature and tale of certifier				29c. Licans	sa number	2	9d. Data signe	d (Month, Day,	Year)	
K	5))		D36+6/ MARCH 3, 1998									98	
3			30. Name and address of person who DR. MICHAEL RIE	BMAN 244	8 HOLLY		UITE	100 ANNA	POLIS, MI	2140	1		
	Sta		31. Date filed (Month, Day, Year)	39. Regist	s Signature	andell							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant'a Name (First, Middla, Last) 2. Data of Death **Physician** Month 1998 March 6:20 A.M. MILDRED WIGGINS /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City GRANADA NURSING HOME If Under 1 Yaar | If Undar 24 Hrs. 8. 5. Social Security Number 9. Birthplace (Stata or Foraign Country)
Maryland 7. Aga (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 F Director Yrs. 212-42-4107 Usual Rasidence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter death with the Manylan Depertment of Health and Mentel Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, "as feocial Examines many any injury or other traumatic event, "as feocial Examines many injury or other traumatic event, "as feocial Examines many any injury or other traumatic event, "as feocial Examines many and any injury or other traumatic event," as feocial examines many injury or other traumatic event, "as feocial examines many injury or other traumatic event," as feocial examines and any injury or other traumatic event, "as feocial examines and injury or other traumatic event," as feocial examines and injury injury or other traumatic event, "as feocial examines and injury or other traumatic event," as feocial examines and injury injury or other traumatic event, "as feocial examines and injury injury or other traumatic event," as feocial examines and injury or other traumatic event, "as feocial examines and injury injury or other traumatic event," as feocial examines and injury injury or other traumatic event, "as feocial examines and injury i 10d. Insida City Limits 1€ Yes 2 No Director Baltimore City Maryland N/A 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 21229 900 Kevin Road U.S.A. Funeral 11. Marital Status 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yes 2 MNo If Yas, Giva Yaar or Dates: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ■ No þ Specify: 3 Widowad 4 Divorced Black Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Dacedant's Education (Specify only highest grada complated) 16b. Kind of Businass/industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Domestic Domestic 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Alexander Thompson Lucille Bryant 19a. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Elsie Thompson/Sister 900 Kevin Road Baltimore. Maryland 21229 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 1 ■ Burial 2 Cremation 3 Ramoval from State 1998 Maryland 4 ☐ Donation 5 ☐ Othar (Spacify) Park 16, King Memorial 22. Name and Address of Facility aggalean Gilmon Mortigian Doing Home 1924 Tark Coad Baltimore, Marylan 21. Signatura of Funeral Sarvice Licensae Henson 23a. Part1. En the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or much failure. List only one cause on each line. rval Between set and Deatl **Physician** /Medical Immediete Causa (Final diseesa or condition rasulting in death) Examiner Examiner bunial-trensit Sequantially list conditions, if any, laading to immediata ceusa. Entar Undarlying Causa (Diseasa or Injury that initiated events rasulting in daath) Last physician s the burial Division of Vital Records, P.O. Box 68760, tension Physician/Medical Part II. Other algnificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown ò 24b. Wera autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy Completed peen hes certificate 200 No 1 Yas 1 ☐ Yas 2 No Hospital or Attending Physician:
 124 hours efter deeth.
 Funeral Director: After this certifical funeral director. 25. Was cese rafarred to medicel axaminar? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 1 Yas 2N No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Tima of 28a. Deta of Injury (Month, Dev Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 2 Accident 5 Pending Invastigation 1 Yas 2 No 6 Could not ba 3 Sulcida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) Location (Streat and Number or Rural Routa Number, City or Town, Stata) illed in by 4 Homicida 1 Certifying Physician: To the bast of my knowladge, death occurred at tha tima, data and place, end dua to tha causa(s) and mannar as statad.

2 Madical Examiner: On the bast of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the causa(s) and mannar stated. 29a. Certifian pletely To the within 2 To the 29b. Signatura and titla of certifiar

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State 31. Data filed (Month, Day, Year)
Registrar MAR 0.4

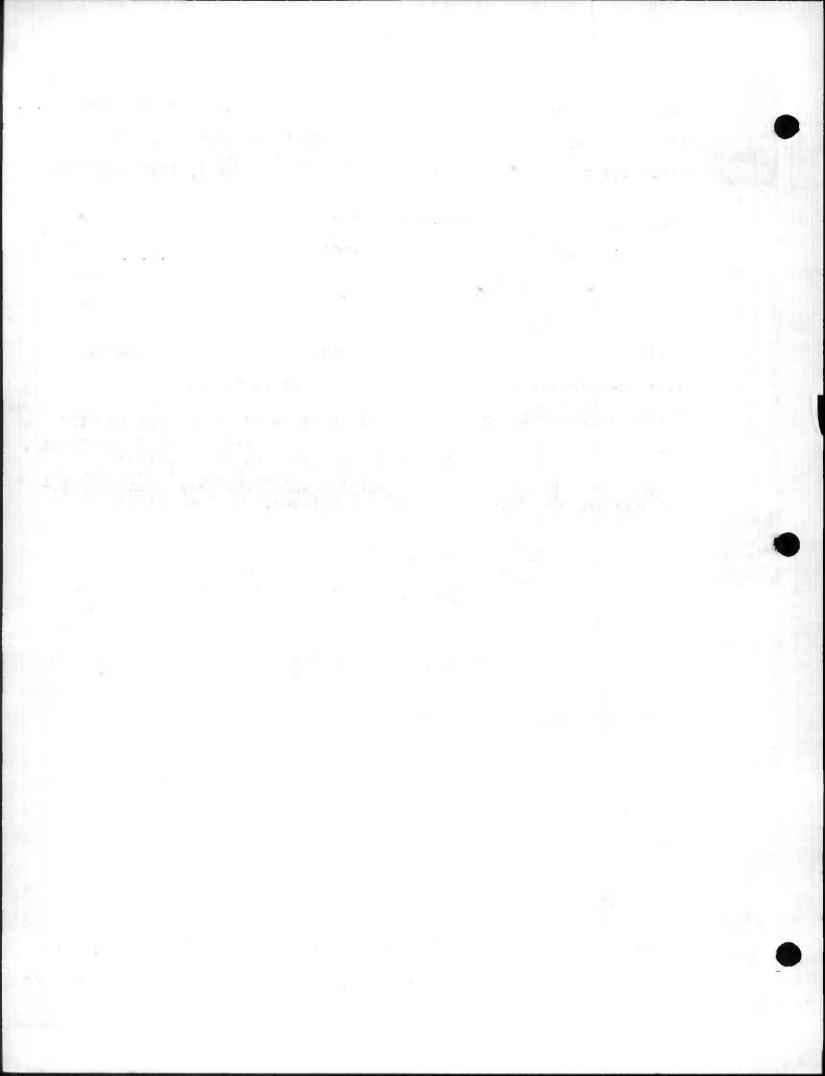
(Month, Day, Year)
MAR 0 4 1998

32. Registrar's Signatura

Rando

30. Nama and addrass of person who complated ceuse of death (Itam 23a) (Type, Print)

lacem



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Deta of Death January 23, 1998 4:55 pm Anna M. Woke 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Bethesda Montgomery Carriage HILL Bethesda 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year II Under 24 Hrs. Days Hours Min. Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) 1 ☐ M 2 🗓 F 726-07-3783 Yrs July 15, 1908 Germany Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 20817 7213 Beacon Terrace 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 11. Maritat Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bteck, White, etc. 1 Never Married 2 Married 1 Yes 2 No White Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'e Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Hospital 12 Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Sumeme) Luise Plate Heinrich Meyer 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 7213 Beacon Terrace, Bethesda, Maryland 20817 Paul Woke/husband 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4XXDonetion 5 ☐ Other (Specify) Joseph B. Van Bant 22. Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Baltimore, Maryland 21201

Baltimore, Maryland 21201

Baltimore, Maryland 21201

Shock, or heeft failure. List only one ceuse on aech lina. Approximete Intervel Between Onset end Death immediete Cause (Finel 2 days diseese or condition resulting in death) Urosepsis Due to (or es e consequence of): 1-2 years Chronic renal infection Due to (or es a consequenca of) Due to (or es e consequenca of) 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evalteble prior to 24a. Was an autopsy completion of cause of deeth? 2 No 1 Yes 1 Yes 2 No 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

attending physician and for usa as the bunal-transit

signed by the ai

page 2 should

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this cartificate has

To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, i

The law requires that the death cartificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If I lem 27 is marked other than "natural" ~ ...

/Medical

10e. State

Director

Funerai

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Completed

Be P

Examiner Physician/Medicai þ Completed

Be 2 Certification:

Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Ceuse (Diseese or Injury that initiated events resulting in daath) Last

Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.

Senile Dementia

Parkinsonism

25. Wes casa raferred to medical examiner?

27. Menner of Deeth 1 Deeth 5 Pending Investigation 2 Accidant

3 Suicide 6 Could not be 4 Homicida

28e. Dete of Injury (Month, Dey Yeer)

28c. Injury et Work? 28b. Time of 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

the Certifying Phyeician: To the best of my knowledge, daeth occurred at the time, date end plece, end due to the cause(s) end menner es steted.

2 Madical Examinar: On the bests of examination end/or investigetion, in my opinion, daeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29a. Certifian

29c. Licansa number

29d. Date signed (Month, Dev. Year)

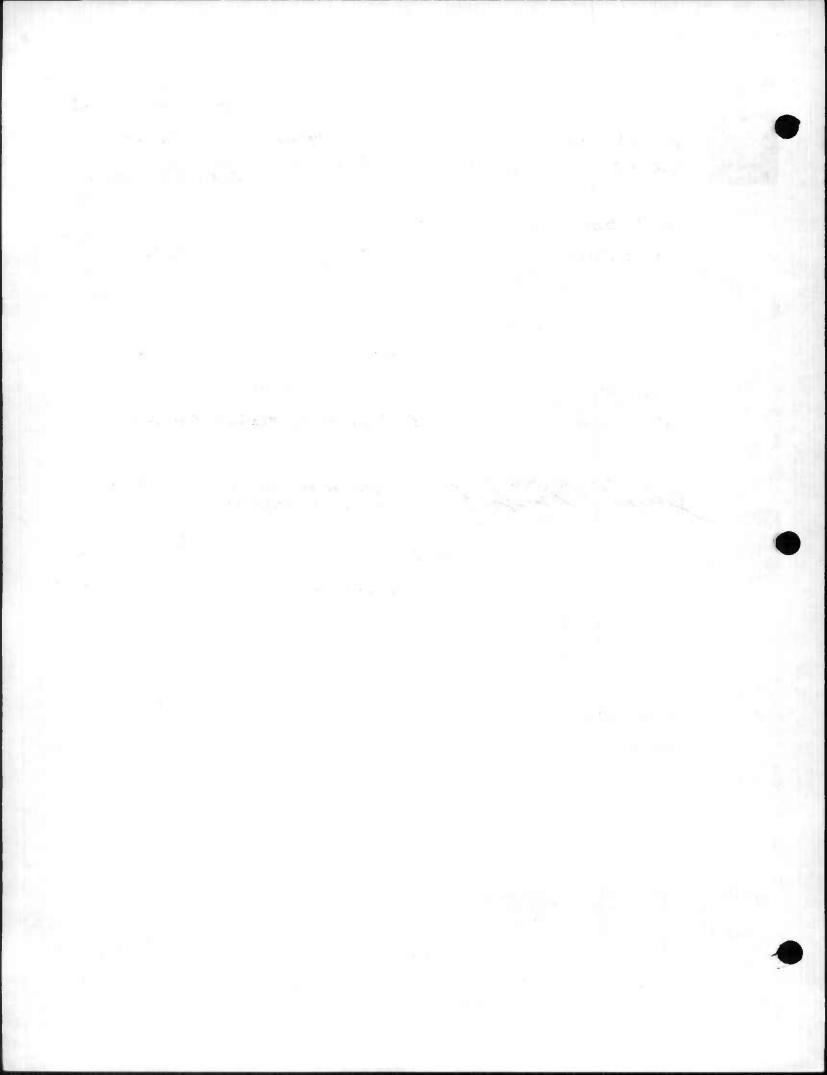
5060 Edmonston 30. Neme and address of person who comple

30 31. Dete filed (Month, Dey, Year)

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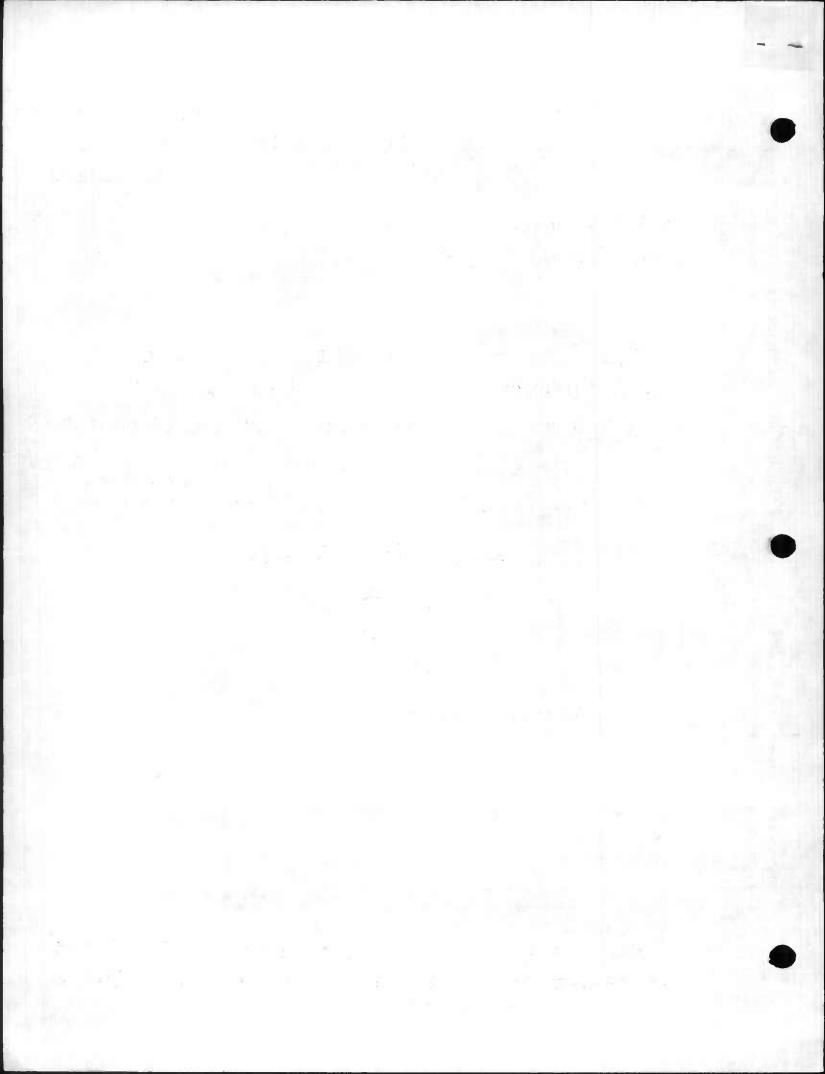
State Registrar

Medical



Please Type or Print in Biack indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Year **Physician** rebruar 26 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** MREATER BALLMORE 5. Social Sacurity Number 6. Sex Baltimor If Under 24 Hrs Medica 9. Birthplace (State or Foreign If Under 1 Yaar 7. Age (In yrs. last birthday) **Funeral** Days Min. Months 1□M 2XF Hours 136 26 6012 Director scott Usual Residence of Decede within 72 hours after death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 K No Baltimore Maryland K 10e. Street and Number Directo OWSON 10g. Citizen of What Country? 10f. Zip Code 13144 Valler 21286 Funerai 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 D No Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yas 2⊠No Specify: Specify: While by 3 ☐ Widowed 4 ☐ Divorcad Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nome UPS marked other permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic event PAGE. 17. Fether's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dulancy Valley Rd Maryland Milton 10WSON. Date March 2 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1⊠Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1998 COMO. 22. Name and Address of Facility EVANS Chimes 21. Signature of Funeral Service Licanses Chapel of 21093 2325 VORK Rd Timonium. 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Kespiva To **Examiner** Due to (or as a consequence of) Physician/Medical Examiner La Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, ettending physician The law requiras that the death certificete by Dua to (or as a consequence of) as the ed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobecco use contribute to the cause of death? been signed by t should be detach 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? Director: After this certificate has d in by the funeral director, page 2 2 ENO 1 ☐ Yes 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3□ DOA 27. Manner of Deeth 1 2 Neturel Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Injury at Work? 5 Pending investigation 1 Yes 2 No deeth 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) after 4 Homicide To the Hospital within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, end due to the ceuse(s) and manner stated. edicai 29a. Certifier complataly (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiar 29c. Licansa number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZOUMI 315ter State Registrar

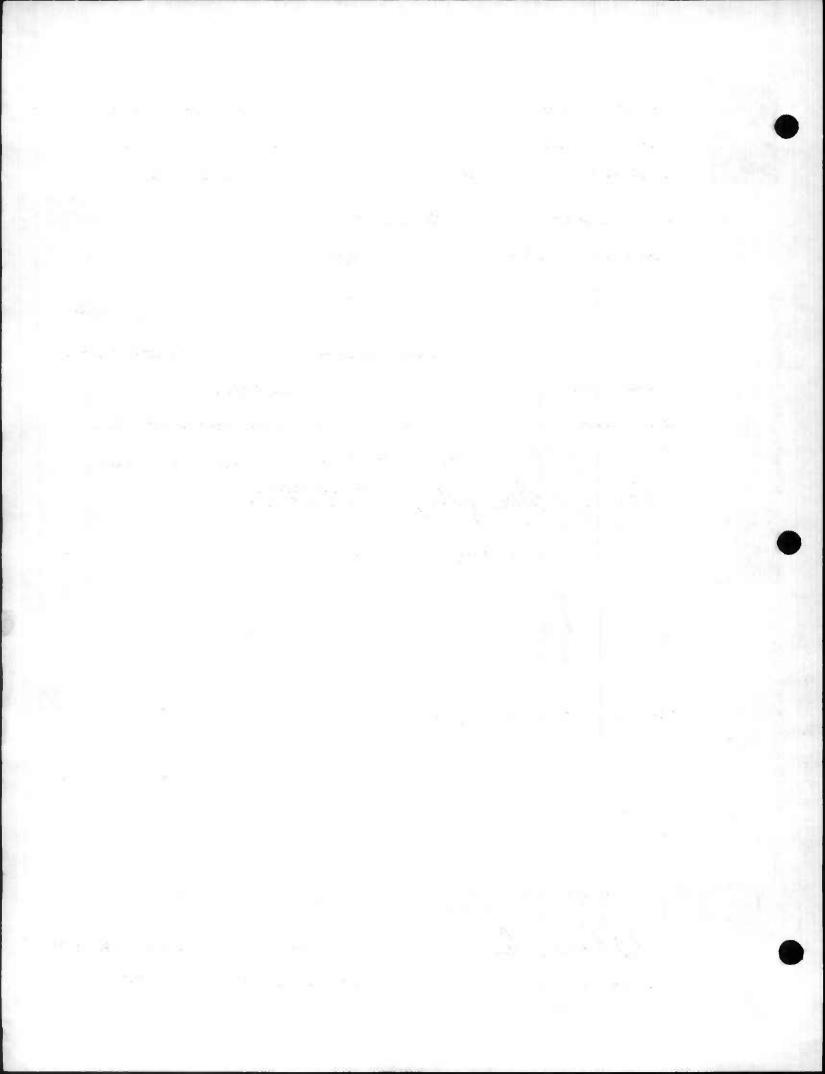


213-94-8238

BRENDA ANTHONY

State of Maryland / Department of Health and Mental Hygiene 98 06719

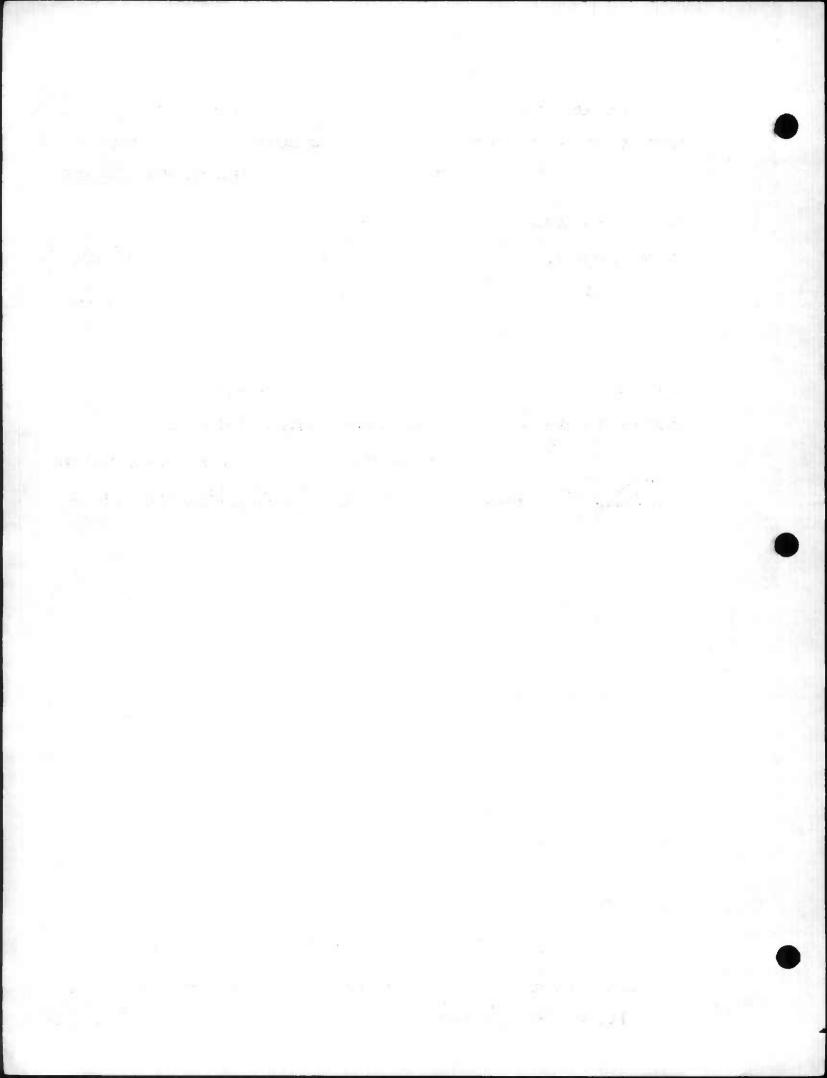
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le n		19e. Informent's Name/Ralation:									al Routa Numb				
m 27	important: If item 27 is marked other than "natural" or items 23s or 23s-f show any injury or other traumatic event, the Medical Examiner mant be notified at once. To Be Completed by Funeral Director	Donna Grimm-mo	othe	r					ld Roa	d SE	Cumber				
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State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate d	of Dea	ath		Reg. No.	IJ	6/20
Physician	_	1. Decedent's Name (First, Middle, La	st)						2, Data of Di	aath Day	Year	3. Tima of Death
/Medical	-	NASIR S	HAKEEL .	AHMED							ARY 13,		4:08 AM
Examiner	-	4a. Facility Nama (if no	ot institution, giv	a street and numb	er)			4b. Cit	y, Town, or L	ocation of Dea			
		NATIONAL I	NSTITUI	E OF HEAL	TH				THESDA			VTGOM	ŒRY
Funeral Director		5. Social Security Num	1	ax 7. ■ M 2 F	Aga (in yrs. las	Yrs.	if Undar 1 Ya Months Da		Indar 24 Hrs. Jura Min.	8. Date of Bi (Month, D APR • 1	th Year) 1956	9. Birth	placa (Stata or Foreign TSTAN
B &	-	Usual Residence of Da 10a. State 1	0b. County		10c. City,	Town or Lo	ocation						10d. inside City Limits
fatho daryt	5		MONTGOM	EDV		ROCKV							1 □ Yas 2 □ No
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and and		19a. informant's Name				19b. Maili	ng Address (Str	eet and A	lumber or Rui	ral Route Numi	ber, City or Town,	State, Zij	Code)
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Department of Health and Mer Important: If then 27 is marke any injury or other traumetic stice.		20a. Method of Dispos 1 Burial 2 C 4 Donation 5 [Premation 3		ita cam	netery, cre	osition (Name or matory or other CEMETE	place)		Date 2/16/98	BHOJPUR		
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ate has been signed by the attending physician and page 2 should be deteched for use as the buriat-transit Compieted by Physician/Medical Examir										10	Yes AS No	11	Yes 22 No
certificate he rector, page		25. Was case referred axaminar?	to medical					26.	Plece of Deel	th (Check only	ona)	1	
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rs after death. at Director: After tilled in by the funera Certification:		3 ☐ Suicida 6 4 ☐ Homlcide	Could not be determined	28a. Place of building,	Injury - At home etc. (Specify)	a, farm, str	reet, factory, offi	Ce Ce			(Streat and Numb own, State)	ber or Run	al Routa Number,
within 24 hours after death. To the Funeral Director: Att completely filled in by the fun completely filled in by the fun Medical Certification		29a. Certifier (Check only one)	Certifying Ph Madical Exam	ysician; To the be- niner: On the basis and manner	of examinetion	edge, deet n and/or in	n occurred at the vestigetion, in m	s time, de ly opinion	te and plece, , deeth occur	end due to the red et the time	cause(s) and ma , dete end place,	anner as a and due t	stated. to the cause(s)
withi To the		29b. Signeture and title	12 A	1997 Wa	١,		HE	onse num	52		29d. Date signe	Month,	Day, Year)
		30. Name and address ANITA	of person who	- 0	f death (Item 23			VILL	E PIKE	, ВЕТНЕ	SDA, MAI	RYLAN	ID 20892
State Registrar		31. Data filed (Month,	to discount of	32.	strar's Signatur	n-yans	AR.						

DHMH 16 Rev 6/95

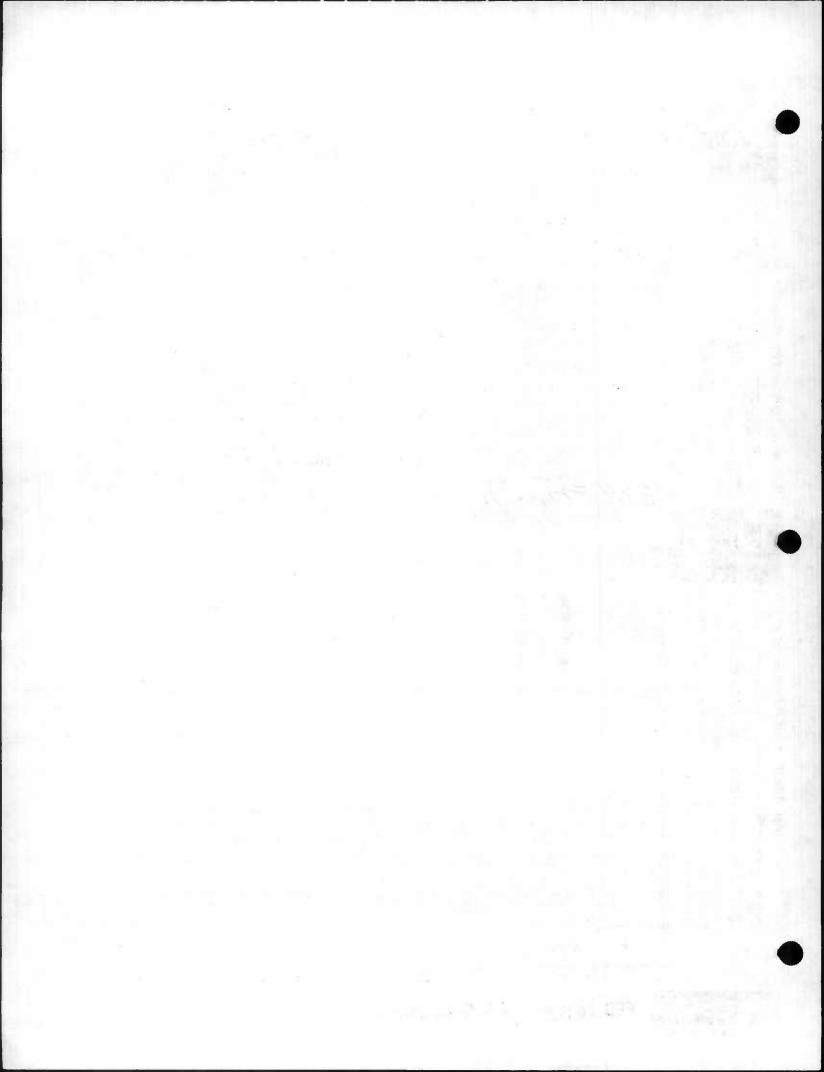


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 8 6 7 2

							Ce	rtificate	9 01	Death			Reg. I	No.			
Г	Physic	ian	1. Decedent's Name (First, Midd	dle, Las	t)							2. Date of D	eeth		Vear	3. Tin	n of Earth
J	/Medi		Richard LaGard									Februa		Ϊ3,	1998	9	30 PM
	Exami	ner	4e. Facility Name (If not institution 9301 Bells Mil	L1 R	load	nber)				Pot	toma			Mon	y of Death tgome	9	
	Funeral Director		5. Social Security Number 579–18–9064	6. Se	X M 2□F	7. Age (In yrs. I. 74	ast birthdey) Yrs.	If Under Months	Days		24 Hrs. Min.	8. Date of B (Month, I Sept. 2	irth Dey, Yea	1923	9. Birthp Cour Wash:	lace (State) Lngt	on, DC
	dand ow		Usuai Residenca of Decedent 10a. State 10b. Count	у		10c. City	, Town or Lo	ocation							1	0d. Insid	le City Limits
	the Mary 28a-f sh	Director	Maryland Mor	ntgo	mery		Potom	ac 10f. Zip	Code				10-	Ohio 4	20/2		Yes 2 No
	3a or		9301 Bells Mil	L Ro	ad			TOT. ZIP		854					What Cour State		
	death death	Funerai	11. Maritei Status	T	12. Was Dece	dent Ever in U,S		Was Deced	ent of	Hispanic Ori	gin? (Sp	ecify Yes or N		14. Ra	ce - Americ	an Indie	n,
Maryland 21215-0020	filed within 72 hours effer death with the Maryland Hygiene. ther than "natural", or flams 23a or 28a-1 show but, the Medical Examinat must be notified at	by	1 ☐ Never Married 2 🕅 Ma 3 ☐ Widowed 4 ☐ Divorce		Armed For 1 X Yes If Yes, Give Yeer or Da	2 No		1 ☐ Yes 2				Rican, etc.)		Specif	ck, White, by: Wh:		
5-0	72 hours "natural",	eted	15. Decede (Specify only highe	nt's Edu	ucation le completed)		16a. Deced	dent's Usual	Occu k done	pation during mos	t of work	cina	16b.	Kind of B	usiness/ind	dustry	
121	d within 72 ho liene. r than "natu	Completed	Elementery/Secondery (0-12)	Ī	College (1-	4or 5+)	life. I	DO NOT us	e retin	ed)		9	C	16 0	7		
d 2	be filed vital Hygie d other event, tr		17. Father's Neme (First, Middle	Last)			Acc	ounta	nt	18 Moths	ar'e Nam	e (First, Middl		117	mploy	ea	
lan		To Be	George Joseph		n					Ruth			o, maio	011 0011101	no,		
ary	8 2 5	-	19a. Informent's Name/Relation	ship (T)	ype, Print)		19b. Mallir	ng Address	(Stree	t end Numbe	er or Rui	ral Route Num	ber, City	y or Town	, State, Zip	Code)	
	and 2 selth e selth e or tra		Betty B. Allen,	/Wif	e		9301	Bells	Mi	11 Roa	ad,	Potomac	, M	ary1	and 2	0854	
altimore,	it. Pages 1 and then the trant: If itam 2 signs or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 4 ☐ Donetion 5 ☐ Other (5			Ce	ece of Dispo metery, cren	natory or of	her pla	uary torium	17,	Dete 1998			City or To		
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V.	Physician		Shook, of Healt landle. Lis	t only of	ne cause on ea	ioi iiie.										Onset a	Between and Death
	/Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)		Cardio	omyopatl	ny									5 Ye	ears
		ě	resulting in Geatin)			Due to (or	as a conseq	quence of):									
	uted Insit	Examiner			b												
,	exect th and riel-tra	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying			Due to (or	es a conseq	juence of):									
68760,	icete be executed physician and s the buriel-transit	ical	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	•	C	Due to (or	es e conseq	uence of):									
×	E 0 6	n/Medical	resulting in death) Last	L,	d												
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	To the Hospital within 24 hours a To the Funeral completely filled	edicai Ce	29a. Certifier (Check only one)	ng Phys	ver: On the bas	est of my know	ledge, death on and/or inv	occurred a	t the ti	me, date and	d piece,	and due to the	cause	(s) end me	enner as st	ated.	se(s)
	ithin 3	Mec	29b. Signeture end title of certific	24	and manne	er stated.		29c.	Licen	se number			29d. D	ate signe	d (Month, l	Day Yes	(r)
				1	/			7	16	495-	-				y 17,		
١	011	-	30. Name and address of person	who en	mpleted cause	of death (Item :	23a) (Tvne I	Print)	10				rel	lual	y 1/,	17:	
			Joel L. Goozh,						105	, Rocl	kvil	le, Ma	ry1a	and 2	0852-	2293	3
	Sta Registr		31. Date filed (Month, Dey, Yeer) FEB 18	1998	32. Re	gistrar's Signetu La Davidson	Ire Abrida	AL.									

DHMH 16 Rev 6/95



December Name (First Medic), Leaf Quintin Amanthanyagam Properties of Properties				Certifica	ite of l	Death		R	eg. No.	U	0/1	44
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Care of Heaven Cemetery 2/16/98 Silver Spring, Mary 2/18 Signature of Funaral Service Licansee 12. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 239. Partit Enter the disease, or complications that cathod the death. Do not enter the mode of dying, such as cardiac or respiratory areas. Approximate inference between an observation of the property of the pro	·		cameter)	orematory of	r other plac	e)		ata	20c. Location	- City or To	own, State	Ð
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State Registrar

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burla-transit

Division of Vital Records, P.O. Box 68760,

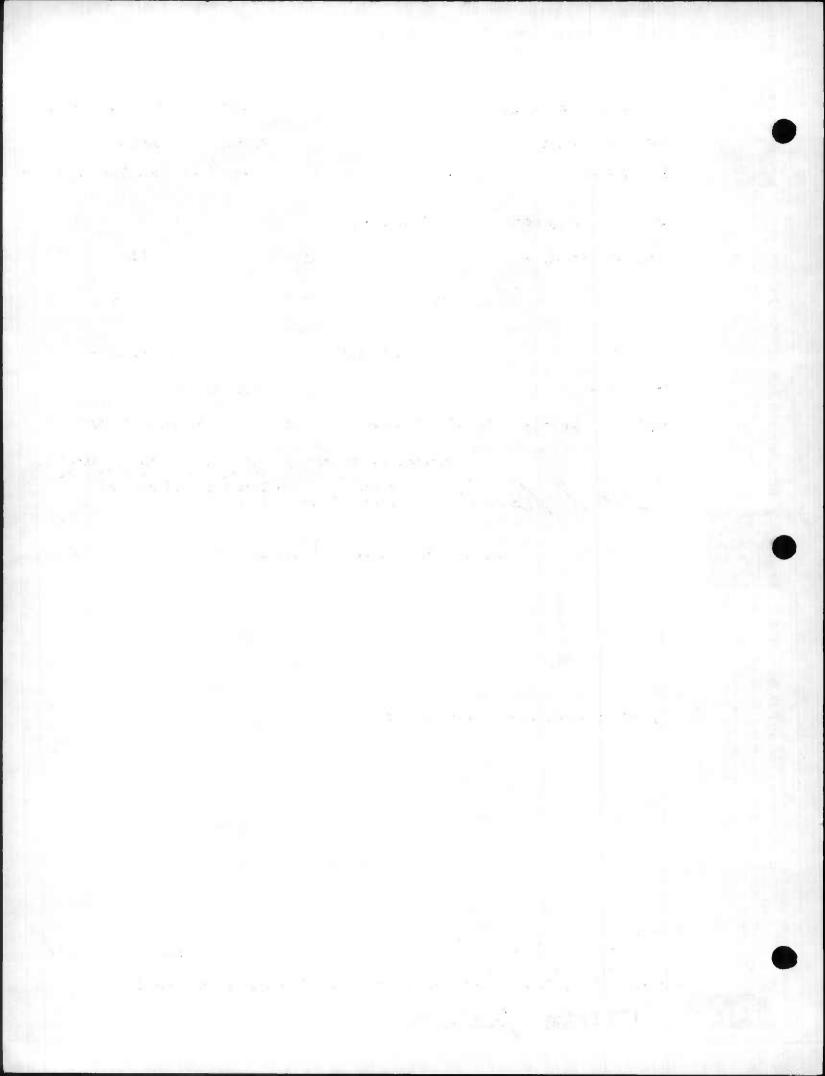
Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificat	e of	Death			Reg. No.	U	0/2.	3
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Physician /Medical		Guido	M. An	toniel								ry 12,		9:00A	M
Examiner	An Plan	cility Neme (If not in	nstitution, giv	e street end nun	nber)				4b. City, To	wn, or Lo	cation of Deet	h 4c. Count	of Deeth		
	H	oly Cross	Hosp	ital					Silve	r Spi	ing	Mon	tgome		
Funeral		ial Security Number		Sex 123 M 2□ F	7. Age (In yrs. I		If Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, De	th 22, Year) 22, 191	9. Birth	plece (Stete o	
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important: it item 27 is marked other than any Injury or other traumatic event, the Mones. To Be Comp	Eler	nentery/Secondary	(0-12)	College (1	-4or 5+)		klaye					Const	ructi	on	
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trau		hyllis E.			(wife)							pring,		0902	
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by th	3[☐ Suicide 6 ☐ ☐ Homicide	Could not be determined	28e. Place	of Injury - At ho	me, farm, st	reet, fector	y, office			281. Location	(Street end Num	ber or Rui	al Route Nun	nber,
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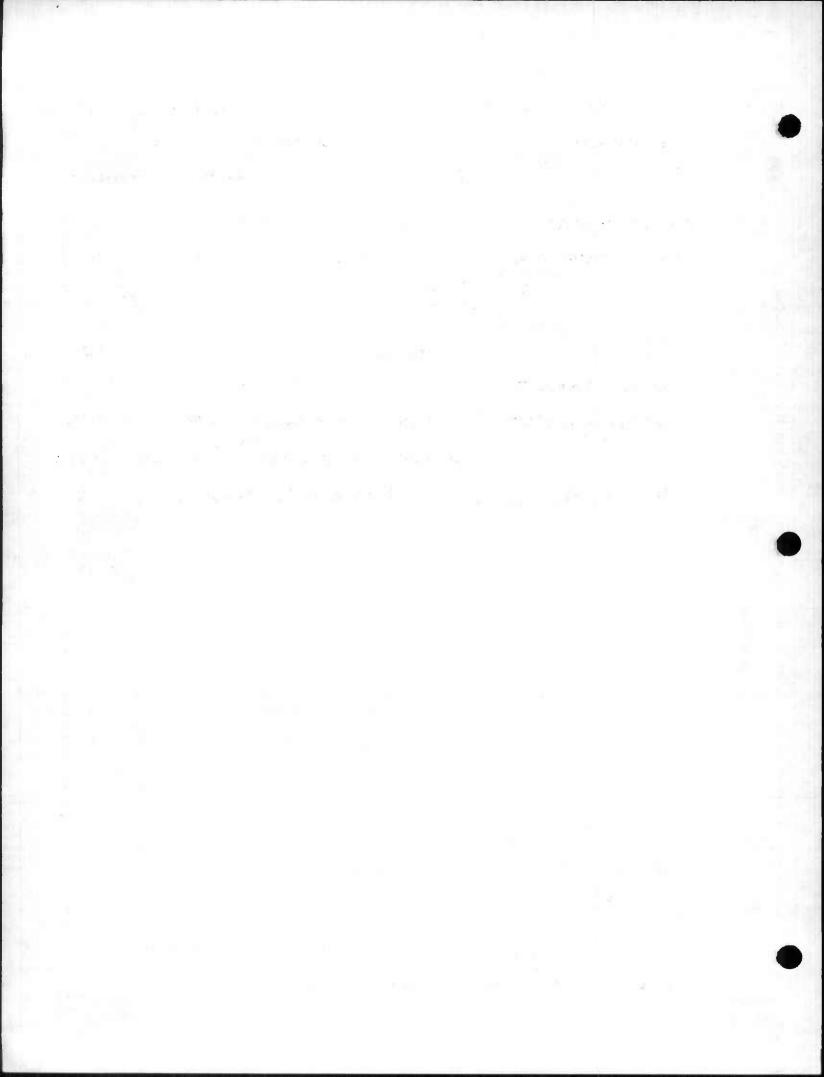


State of Maryland / Department of Health and Mental Hygiene

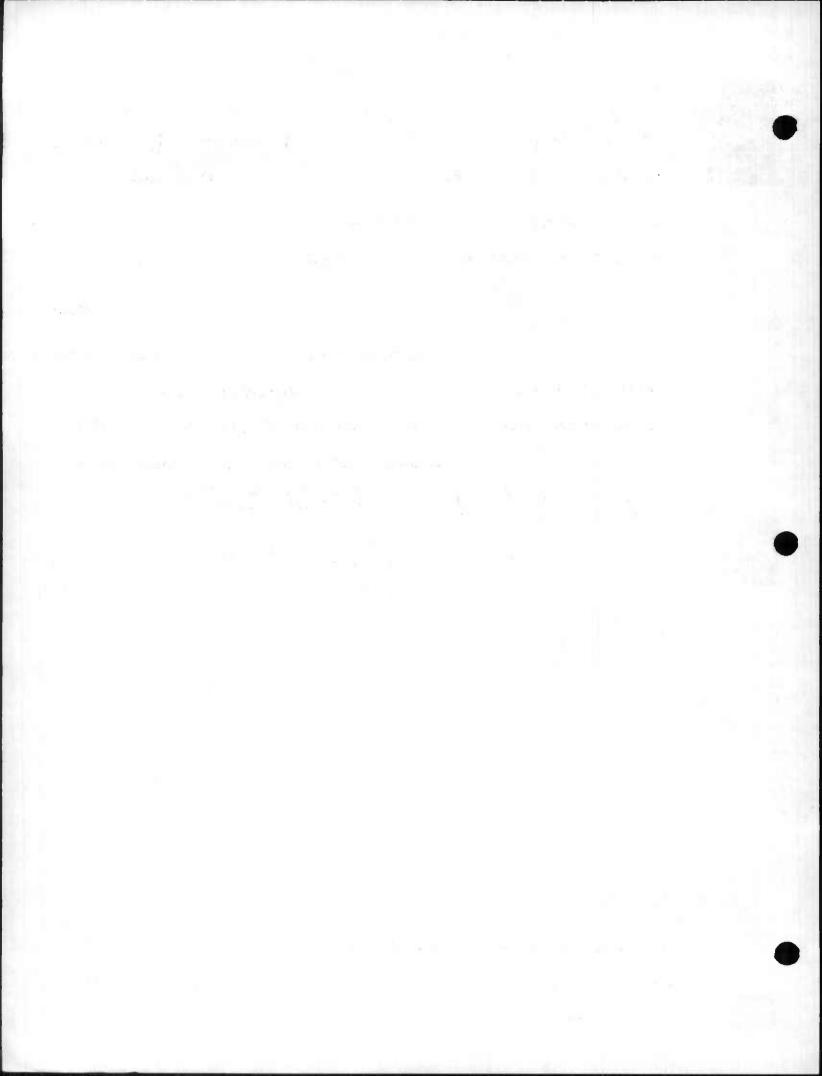
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Vaai **Physician** DANIEL HERBERT ARNOLD, JR. FEBRUARY 11, 1998 6:18 am /Medical 4e. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□ F Deys Yrs. Director 706 09 4669 77 JUNE 25 1920 MARYLAND Usuel Residence of Decedent the Marylenc 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or items 23s or 28s-f sho traumetic event, the Modical Examinar must be notified at 1 Yes 2 No Director MT SAVAGE MARYLAND ALLEGANY 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with Department of Heelth end Mental Hygiena. Important: If item 27 is marked other than any Injury or other traument. 238 14414 MT SAVAGE ROAD, NW 21545 Funeral U.S. 12. Was Decedent Evar in U.S.
Armed Forces?
1 Xi Yas 2 \(\text{\text{\text{N}}} \) 7 / 10 / 44
If Yes, Give
Yeer or Dates: 1/21/46 Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Navar Married 2 Merried 1□Yes 2 No Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) MACHINIST KELLY SPRINGFIELD TIRE 10 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surname) Be DANIEL H. ARNOLD, SR. RUTH C. MILLER 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) GERALDINE ARNOLD/WIFE 14414 MT SAVAGE ROAD, NW, MT SAVAGE, MD 21545 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 2/14/98 1 X Burial 2 ☐ Cramation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) ST GEORGE'S EPISCOPAL CEM MT SAVAGE, MD 21545 21. Signeture of Funeral Service Licenses 22. Nama and Address of Fecility SOWERS FUNERAL HOME, 60 WEST MAIN STREET, P.A. FROSTBURG, MD 21532 23a. Pert1. Entar tha disease, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or raspiratory arrest shock, or heert failura. List only one cause on aach line. **Physician** Immediata Cause (Finel diseesa or condition resulting in deeth) /Medical Ventricular tachycardia 10 minutes Examiner Due to (or as a consequence of): Examiner 10 minutes Acute myocardial infarction To the Hospital or Attending Physician: The iew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completally filled in by the tuneral director, page 2 should be detached for use as the burlet-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initioted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Dilated cardiomyopathy 5 years Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Acute renal failure, cachexia, depression by 24b. Were eutopsy findings evellable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 2 No 1 □ Yes 2 □ No Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 27. Magner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending Invastigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homlcide 1% Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as steted.
2 Madical Examiner: On the basis of exeminetion and/or invastigation, in my opinion, deeth occurred at the time, dete and place, and dua to the cause(s) end mannar steted. 29a. Certifier Medical 29b. Signeture end title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) D 19318 February 12, 1998 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Dr. Ranjithan, 517 Oldtown Rd., Cumberland, MD 21502 31. Deta filed (Month, Dey, Year) 32. Registrar's Signature State FEB 1 8 1998 a water windowl

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iner		la. Fecility Name of not	institution, give	street end number, yeland Mi	di col	Syst	em	4			cation of Deal		or De	more
ai or		5. Social Security Numb 178-07-3 Usuel Residence of Dec	387	9x 7. Ag	ge (In yrs. le:	st birthday) Yrs.	If Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Do Jan	rth ey, Year) 14, 19	(irthplece (State or I Country) PA
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Director	3	10e. Street and Number		<u>1</u> <u>y</u>		Canbo	10f. Zip	11.11				10g. Citizen	of Whet C	
		13008 Mallard	l Street 1	Bowling Gree	en			215	0 2				USA	
/ Funerai		11. Marital Status 1 ☐ Never Married	2□ X arried	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give	Ever in U,S.	1f	/as Deced Yes, spec	dent of H cify Cube	ispenic Orl	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	E		nerican Indien, nite, etc.
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		E. Ruth	Altizer	-wife		13008	Malla	rd St	reet B	owlin	g Green	Cumberla	and MD	21502
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MIKE	-	21. Signature of Funeral	Service Licens	see Ma	/		Name en	d Addres	ss of Facilit	unera	al Home	e, P.A.		and m
		23e. Pert1. Phter the di- shock or heart fail	iseese, or comp lure. List only o	lications thet cause one ceuse on eech li	d (lie death.	Do not ente			land I			errest,		Approximete
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i r	-	Immediate Cause (Final disease or condition resulting in death)	d	Cor	ona	y /	Art	ly		1.0				Onset end De
r	ł	diseese or condition	ıl	. Cor	On an	y /	Art	ly		1.0	casc			Onset end De
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State of Maryland / Department of Health and Mental Hygiene 98 06726

						Cert	ificate of	Death	F	Reg. No.	J	0120
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	Physici /Medic		Louis	se H. Abbot	tt				Februar	ry 20,	1998	4:40 a.m.
	Examir		4e. Facility Name (If not institution, g					4b. City, Town, or L		4c. County		
			Edw.W.McCready I					Crisfiel		Somer	set	
	Funeral Director		213-22-8241	Sex 7. Age (i	'In yrs. last bit		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, De) July 1	(, Year)	Cour	olece (Stete or Foreign oryland
	pue *		Usuel Residence of Decedent 10a. Stete 10b. County	1	Oc. City, Tow	m or Loca	ation				1	0d. Inside City Limits
	Aeryle	5		erset				field			'	1 X Yes 2 No
	the the	ect	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhet Cour	ntrv?
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Depertment of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examinat must be notified at ance.	Funeral Director	307 Myrtle S				218			USA		
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Baltimore, Maryland 21215-0020	ours aft rai', or	Completed by F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 ☐ Yes 2 🔏 No If Yes, Give Yeer or Detes:		10	JYes 2 № No	Specify:		Specify	. Whi	ite
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lan	2 sho and 1 is me		19e. Informent's Neme/Reletionship					t end Number or Ru		-	Stete, Zip	Code)
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Iţi	ortme ortani ortani		4 ☐ Donetion 5 ☐ Other (Special Signature of Funeral Service Lice	**	50. 00		Name and Addre		./ 23/ 30	DEGI I	21011	1, 110
Ba	Depe Impo		Robert H.	Jacen V6	mes		Bradsha	w & Sons Main St.			D 21	1817
Г			23a. Pert1. Enter the diseese, or co shock, or heert feilure. List on		e death. Do	not enter	tha mode of dyl	ng, such as cardiac	or respiratory ar	rest,		Approximete Intervel Between
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1	/Medical Examiner		Immadlete Ceuse (Finel disaasa or condition		140 ca	udic	il I	yauctio	m			
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	certificate be executed rding physician end use as the buriel-transit	Examiner	Sequentielly list conditions, if eny, leeding to immediate	Du	ie to (or es a	conseque	ence of):					
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of Vital Records,	law requires as been sign 2 should be	Completed							24a. Wes perfor	en eutopsy med?	av	ere eutopsy findings ellable prior to empletion of cause
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<u> </u>	Physician: The lav rthis certificate has ral director, page 2	o Be	25. Wes case referred to medical exeminer?	Hospitel:	7		Oti	26. Plece of Dee				
	Phys ratidi	1-	1 Yes 2 No 27. Menner of Death	1 L Inpatient		itpatient Time of	3L DOA	4 Li Nuising H	ome 5 Resid			(y)
חס	ding th. Afte	tion	1 Naturel 5 ☐ Pending investigat	28a. Dete of Injury (Month, Dey Y	(ear)	Injury	28c. Inju Wo M 1	rk? Yee 2□No				
Division	Attending ir death. actor: After by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not	be 28e. Placa of Injury	- At home, fa	arm, stree	at, fectory, office				er or Rura	al Route Number,
ă	al or Attending P s efter death. I Director: After ti d in by the funera	ent	4 Homicida	building, etc. (Specify)				City or Tow	n, Steta)		
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edicai C	(Check only 2 Medical Ex	hyelcien: To the best of mainter: On the basis of ex	reminetion en	e, deeth o	occurred et the ti	me, dete end pieca, opinion, deeth occui	end due to the or	ceuse(s) end me	enner as s	teted. o the ceuse(s)
	the the	Med	one)	end manner stated	d.	-	20c Licani	ea number	- 1-	20d Date signs	d /Month	Day Voorl
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			30. Neme end eddress of person who Dr. Vijay Karu	mhunathan M	1cCrea	dv Ho	snital.	Crisfie	ld. Md.			
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registrer's	Signature	<i>A</i> -	.A		,			
	Registr	_	FEB 2 5	32. Registrer's	Musican	Karde	M.					

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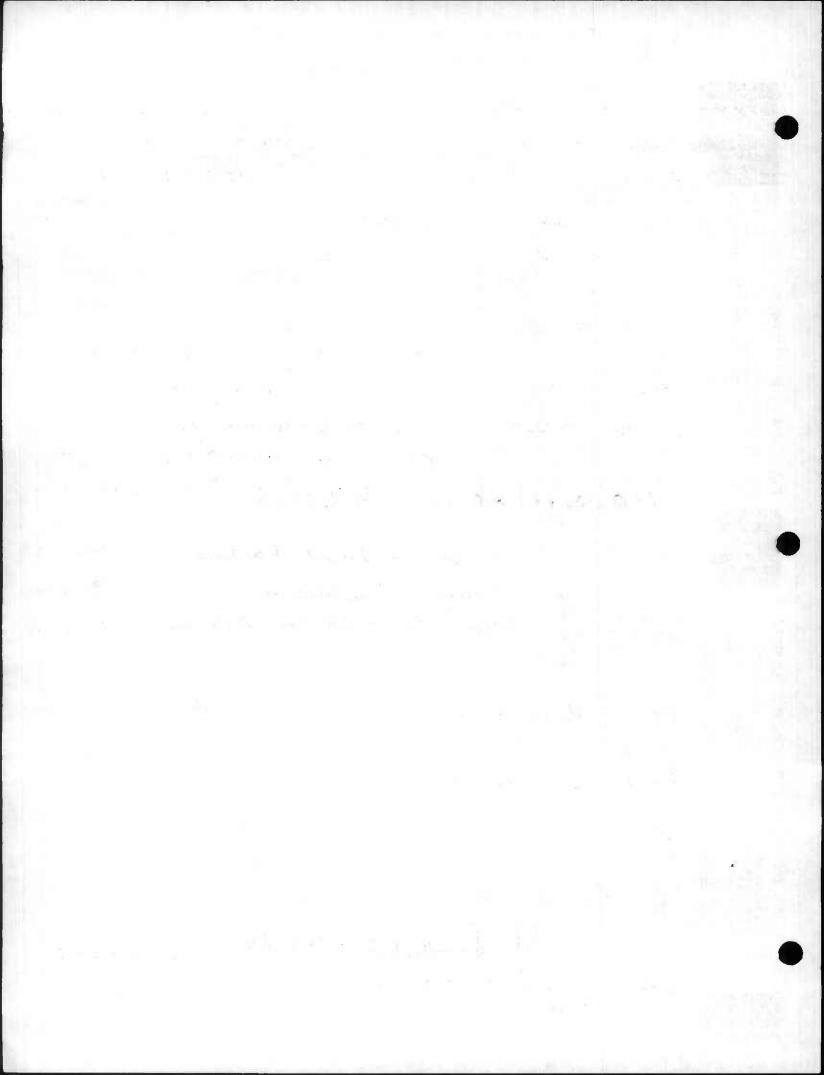
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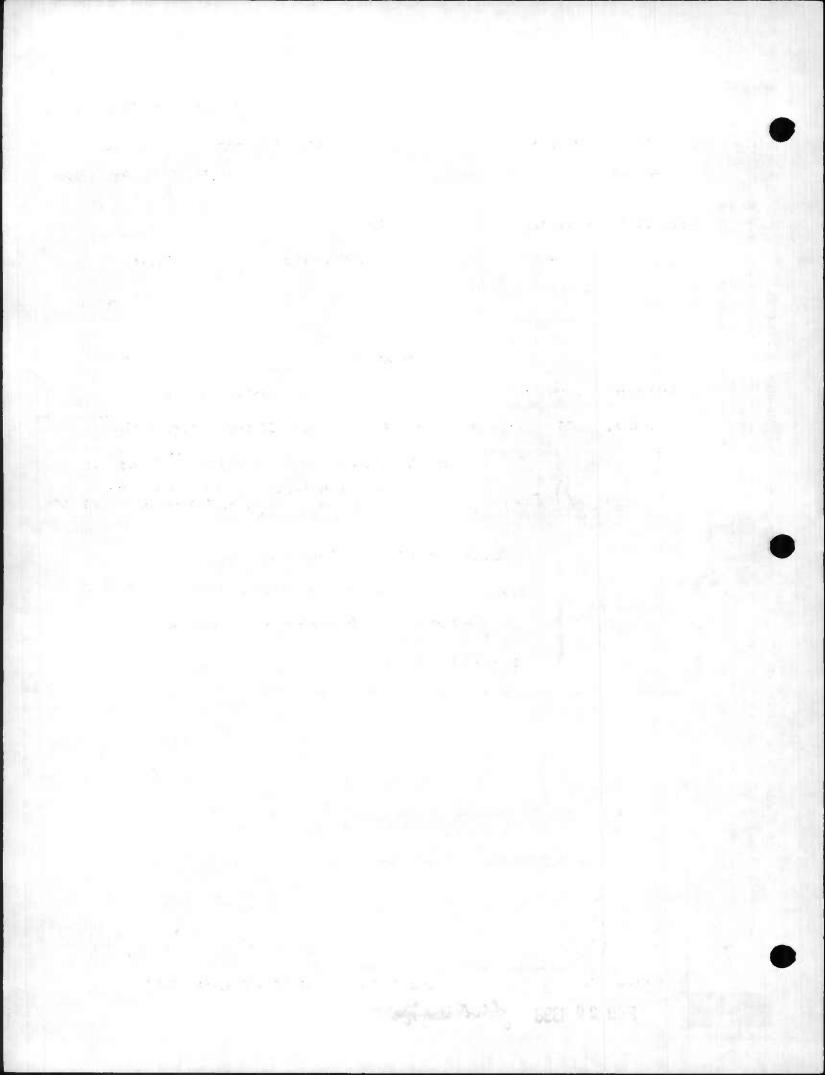
Marking Manager

its shall a section 2/23/49 as whether a

Physic /Medi	cal	1. Decedent's Namy (First, Middle, Last) NORRIS LEE B		Cer	tificate			2. Date of De Month FEBRUA	ARY 20 1	
Exami	ner	4a. Facility Name (If not institution, give street SACRED HEART HOSPI 5. Social Security Number 6. Sex	TAL	in no briedh day d	If Under 1 Y	C	ity, Town, or U UMBERL Under 24 Hrs.	The same of the sa	ALLEG	ANY
Funeral Director		214 07 4056 Usual Residence of Decedent	7. Age (In yrs. In 78	Yrs.			ours Min.	8. Date of Bir (Month, Da MAY 22		9. Birthplace (Steta or Country) MARYLAND
ors enter beauti with the melytend all, or items 23e or 28a-f show Examinet man be notified at	rector	10a. State 10b. County MARYLAND ALLEGANY 10a. Street and Number 1, (4)		FROSTB		de			10g. Citizen of	10d. Inside City 1 ☐ Yes
order with	Funeral Director	20611 KLINDIKE ROAD 11. Maritai Status 12. W	as Decedent Evar in U,S		21 Vas Decedant	532 of Hispa	nic Origin? (Sp	pecify Yas or No	U.S.	ee - Amarican Indian,
	by	1 Never Married 2 Married 1] 3 Wildowed 4 Divorced Y	X Yas 2 □ No Yes, Give ear or Datas: WW II	1	☐ Yes 2【X	No Si	exican, Puerto pecify:	Hican, atc.)	Specify	WHITE
jene.	Completed	15. Decedent's Education (Specify only highest greda com Elementary/Secondary (0-12)	pletad) ollege (1-4or 5+)	(Give I life. D	ent's Usual O kind of work d OO NOT use n	one durin etired)	g most of worl	king		E CORP.
nen of Health and Mentel H int: If Item 27 is marked out ury or other treumatic even	To Be C	17. Father's Name (First, Middle, Last) BENJAMIN BROADWATER					Mother's Nam	e (First, Middle, MAY GRO	Meiden Suman	
		19e. Informant's Name/Relationship (Type, Principle) ETTZABETH BROADWATER 20e. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Remove A ☐ Donation 5 ☐ Other (Specify)	/WIFE 20b. Pi	20611 ace of Dispos		IKE of plece)	ROAD,	FROSTBUR Date	RG, MD 2	Stete, Zip Code) 21532 City or Town, Stata URG, MD 2153
Departm Importan any Injur		21. Signature of Euneral Service Licensee	. Sowe	22. SO FR	Nama and A WERS F OSTBUR	ddrass of	Facility AL HOM D 2153	E, P.A.,	60 W. M	MAIN ST.
hysician /Medical xaminer		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one caulinmediate Cause (Final disease or condition resulting in death)								Approximate Interval Betw Onsat and D
e ettending physician end of for use es the buriel-transit	Physiclan/Medical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	Hyperlin	as a consequ	Jence of):		Lew Sig	vilure Disc	one	304
ed by the ett deteched fo	by Physica	Part II. Other significant conditions contributions Chronic Ruel	Failur	Iting In the un	derlying ceus	e given In	Part I.	23b. Did 1	/	ntribute to the cause of
0 0		Dabetes mel	lits'					24a. Was perfo	an autopsy med?	24b. Were autopsy fir available prior to completion of ca of death?
s been sign 2 should be	mplet	(V)						101	res 2 No	1 Yes 2 1
s certificate hes been signi director, pege 2 should be	To Be Completed	25. Was cese referred to medicel examiner? 1 Yes 2 No Hospite	left le	ER/Outpatient	3□ DOA	Other		th (Check only o		er (Specify)
ufer this certificate hes been signuneral director, pege 2 should be	To Be	examiner? 1 Yes 2 No Hospita 27. Menper of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Sulcide 6 Could not be	1 by inpatient 2 E	28b. Time of Injury	28c.	Other: Injury at Work?	☐ Nursing Ho	ome 5 ☐ Resid 28d. Describe t	lence 6 Doth	red
After this certificate hes been signifuneral director, pege 2 should be	Be	examiner? 1 Yes 2 No Hospita 27. Menger of Death 1 Natural 5 Pending investigation 2 Accident investigation	Dete of Injury (Month, Dey Year) Delease of Injury - At hor building, etc. (Specify) To the best of my know	28b. Time of Injury me, farm, stre	28c. M et, factory, of	Other: 2 Injury at Work? 1 Yes	Nursing Ho	28d. Describe to 28f. Location (Scity or Town	dence 6 Oth now Injury occur Street and Numb vn, Stete)	per or Rural Route Numb

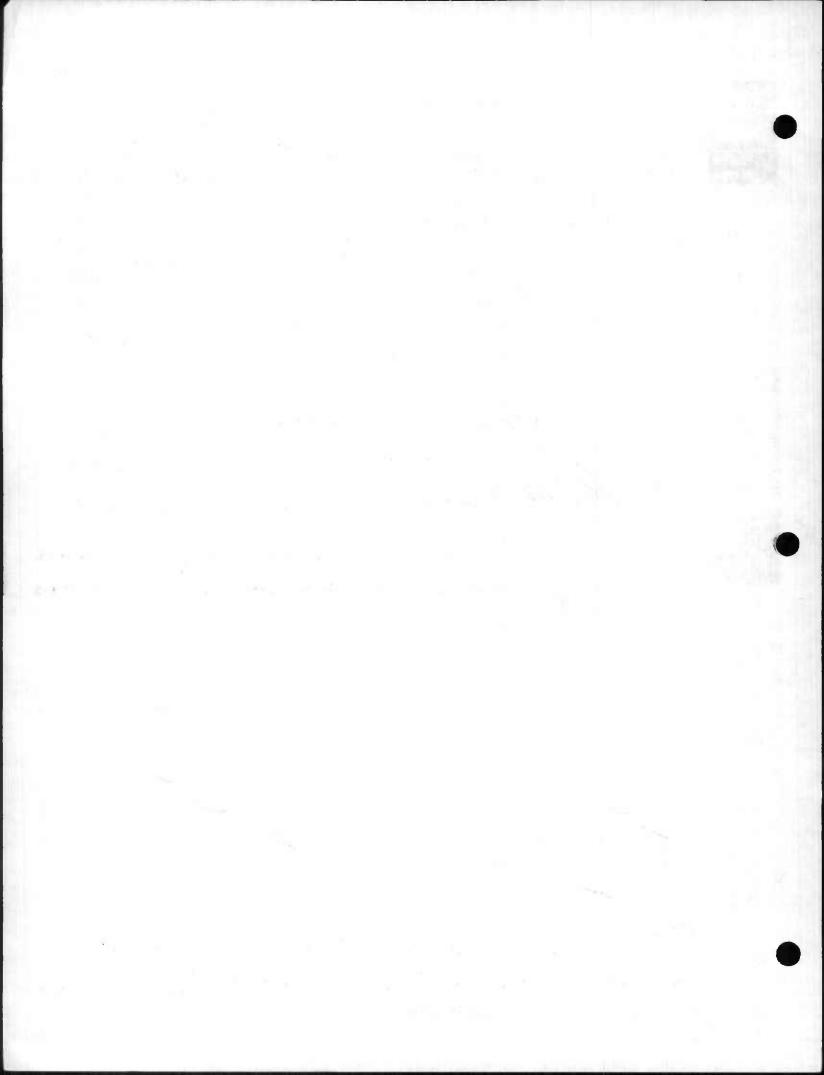


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an	Doro	thy	Irene		R-	uell				Febr		17, 1	Year	0.10
al er	4e Facility Neme					uczz			4b. City, Town,		-	4c. County	-	9:10
		cala Sti												
	5. Sociel Security		6. Sex	7. A	ge (In yrs. le	st birthday)		er 1 Year		Irs. 8. Date	of Birth	Montg	9. Birth	olace (State or ntry)
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	Usuel Residence				70					1000	24,1	721	rem	isyrvan
	10e. Stete	10b. County			10c. City	Town or Loc	cation							10d. Inside Cit
	Maryland	Montgo	omerv		Si	lver S	Sprin	no						1 🗆 Yes
	10e. Street end Nu							ip Code			10g.	Citizen of V	Whet Cou	ntry?
	9410 Oca	ala Stro	oot				20	1901-	-3046			U.S.A		
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	3 Widowed	4 Divorced	Ye	Yes, Give ear or Detes:			LITES	SKI NO	Specify:			Specify	Whi	Ite
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-	Alexande	er McC	Quiston	n					Mare	aret	Mill	Ler		
	19e. Informent's N	Neme/Reletions	hlp (Type, Pn	nint)		19b. Mailing	g Addres	ss (Street	end Number or					
tant: If item jury or othe	Gerald A	A. Buell	1 (1	husbar	nd)	9410 0	cala	a Sti	eet Si	lver S	pring	Mary	land	901-30
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	shock, or he	art failure. List	only one ceu	se on eech I	line.								-	Intervel Bety Onset end D
	Immediate Course	/Final												
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth **Physician** Month Barbara Smith Bannister 7:28 p.m. February 13, 1998 /Medical 4a. Facility Nema (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 2 Avon Place Prince Georges Avondale if Under 1 Yaar if Under 24 Hrs. Months Deys Hours Min. 5. Sociei Security Number Birthplece (State or Foreign Country) 7. Aga (In yrs. lest birthday) **Funeral** Deys 1 □ M 2 🛛 F 56 yrs. Director 230-52-3485 April 7,1941 Bremo Bluff, VA Usual Residence of Decedent the Meryland 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "naturel", or items 23a or 28s-f show other treumstic event, the Medical Examinar mast be notified at Director 1 Yes 2 □ No Prince Georges Avondale 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2 Avon Place 20872 Funeral U.S.A. 12. Was Decedant Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Ricen, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours efter Hygiene. 1 ☐ Yes 2 ☐XNo If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Dacedent's Education (Specify only highest greda complated) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed withir Department of Health end Mental Hygiene Important: If frem 27 Is marked other than any Injury or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) U.S. House of 12 Executive Assistant Representatives 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Cleophas Smith 2 Eva Creasy 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiting Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Barbara G. Bannister/Daughter 2 Avon Place, Avondale, MD 20872 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Data 1 ☐ Burial 2 X Cremetion 3 ☐ Ramovel from Stata 4 Donetion 5 Other (Specify) Chesapeake Crematory, Inc. 2/17/98 Beltsville, MD 21. Signeture of Funeral Service Licersage 22. Name end Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington, DC 20012 11. Enter the disease, or complications thet caused tha daath. Do not enter tha mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset end Deeth **Physician** /Medical immediate Ceuse (Final cerebral 24 HRS diseesa or condition resulting in deeth) Examiner lynaut mos The lew requires that the death certificate be executed -trensit Sequentially list conditions, if eny, teeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events rasulting in deeth) Last and Due to (or es e consequence of) P.O. Box 68760, ettending physician for use as the burie Physician/Medical Due to (or es a consequenca of): USB BS Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Yes 2 No Records, by 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to complation of ceusa of deeth? Completed peen hes pege 2 1 Yes 1 TYes 2 TNo certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours efter death, 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Hesidenca 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending invastigation 1 Natural within 24 hours efter death. To the Funeral Director: A 1 Yes 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) à 4 Homicide 29e. Certifier Contifying Phyeician: To the best of my knowladge, death occurred et the time, dete end place, and due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated. ature end title of certifiar 29c. Licansa number 29d. Deta signed (Month, Day, Year) 211719 of deeth (Item 23a) (Type Print) 31. Dete filed (Month, Dey, Year) 32 Registrer's Signeture State his Devidson Registrar FEB 19 1998



State of Maryland / Department of Health and Mental Hygiene 0.0

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Funera	al	5. Sociel Sacurity Number 6.		a (In yrs. lest bir	thday) If Under 1 Ya	aar If Undar 24 Hrs.	8. Date of Birth (Month, Dey,)		Birthplaca (State or Country)	r Foraign
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aryland	_	10a. State 10b. County		10c. City, Town					10d. Inside City	lie i
Me M	Director	Maryland Montgom	ery	Gait	hersburg				1 🗵 Yes	2 🗆 NO
ith th	듬	10e. Street end Number			10f. Zip Cod	le	100	g. Citizen of Wha	at Country?	
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ore, Maryland 21215-0020 s.1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene. Item 27 Is merked other than "natural", or itams 23s or 28s-f show other traumatic event, the Medical Examples must be notified at	by Fu	1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2XI If Yes, Give Year or Detes:		1 ☑ Yes 2 ☐	No Specify:	ombian	Specify	White, etc.	
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Aai 2 sh and and Is m		19e. Informent's Name/Reletionship	Type, Print)	19b	Mailing Address (Str	reet and Number or Ru	re i Route Number, (City or Town, Ste	ete, Zip Code)	
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If Itam 27 I		Gloria Blum/Wife		28	Spring St	reet, Gait	hersburg,	Maryla	nd 20877	
of H		20a. Method of Disposition	7.0	20b. Plece of	Disposition (Name or	f			ty or Town, Stete	
Baltimore, bermit. Pages 1 ar Department of Hea moortant: If Itam;		1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Control of the Cont				Cemetery	2/16/98 5	ilvar S	oring MD	
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Ball Department of the same of		NO 0	A (00		De	Vol Funer	al Home		
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777		23a. Part 1. Enter the disaase, or com shock, or heart failure. List only	plicetions that causac one ceuse on eech li	d tha death. Do r ne.	ot antar the mode of	dylng, such es cardiac	or respiretory erres	t,	Approximete Intarval Betw	
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ecords, P.O. lew requires that the as been signed by the 2 should be deteched	F						1 🗆 Yes	2 □ No 3	☐ Probably 4 🕱 U	Jnknown
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On Oi ding Phy h. After thii funeral	ü	27. Menner of Deeth 1 Naturel 5 □ Pending	28e. Date of Inju (Month, De		ime of 28c. In jury	njury et Work?	28d. Describe how	Injury occurred		
UIVISION OF VITAI or Attending Physician: T efter death. Director: After this certificet d in by the funeral director, p	atic	2 Accident investigatio				I ☐ Yes 2 ☐ No				
VIS Affe or de by ti	iji.	3 Suicide 6 Could not be determined	286. Pieca of inj	ury - At home, fa	m, street, fectory, offi	ce	28f. Location (Stre	et end Number	or Rural Route Numb	oer,
ב ב ב ב ב	Certification:	4 - Homode	building, ef	с. (эреспу)			City or Town,	21616)		
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DIVISION Control of Attending P within 24 hours effer death. To the Funeral Director After the completely filled in by the funeral process.	Z e	29b. Signature and title of certifier	3		29c. Lic	ense numbar	294	I. Date signed /	Month, Dey, Yeer)	
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5		M (reun	ILL	00	3716		71490	7	
		30. Name and address of person who	completed cause of d	eeth (Item 23e) (Type, Print)					
		Tibor E. Frekko, 1	M.D., 1921	1 Montgo	mery Villa	age Ave.,	# B10, Ga	ithersb	urg, MD.20	0879
S	tate	31. Dete filed (Month, Dey, Yaer)	32. Registra	ar's Signeture						
Regis	trar	FEB 17199	8 gira	Davidson-A	MARINE					

DHMH 16 Rav 6/95

				C	ertificate of	Death		leg. No.	U) / 3
		1. Decedent's Name (First, Middle, L	ast)				2. Dete of Dee	oth	Vaar	3. Time of Death
Physi		Joseph	Edward Butle	. Jr			Month Februar	Dey 17. 1	Year 998	2:10 PM
/Med Exam		4a Facility Neme (If not institution, g		, ,		4b. City, Town, o	r Location of Deeth			2.10 111
		19712 Mayhill Te	rrace			Gaither	rehuro	Mon	tgome	rv
Funera			Sex 7. Age (In yrs. I	ast birthde	y) If Under 1 Yea	r If Under 24 Hr	s. 8. Dete of Birt	1101		ice (State or Foreign
Directo		219-48-1827	1⊠M 2□F 51	Yrs.	Months Day	s Hours Min	May 28,	1946		ngton, D.C
9		Usuel Residence of Decedent								
anytar d at	_	10a. State 10b. County	10c. City	, Town or	Location				100	d. Inside City Limits 1 ☐ Yes 2 ☑ No
88-f	Director	Maryland Montgo	mery G	aith	ersburg					
or 2	Dire	10e. Street end Number			10f. Zip Code			10g. Citizen of 1	What Countr	yγ
ath w	Funeral	19712 Mayhill To	T T		2087			Unite		
ar de	nue	11. Marital Stetus	12. Wes Decedent Ever in U, Armed Forces?	5. 1	Was Decedent of If Yes, specify Cu	Hispanic Origin? (ben, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	Blee	e - America ck, White, e	
15-0020 72 hours after death with the Manyland "natural", or items 23s or 28s-f show	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorcad	1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates:		1 ☐ Yes 2 🔀 N	Specify:		Specify	. Wh	ite
215-0020 thin 72 hours af a. "natural", or	Completed	15. Decedent's (Specify only highest g	Education rade completed)	16e. De	cedent's Usuel Occ	upation e during most of w	odkina	16b. Kind of B	usiness/indu	istry
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aryland 212: should be filed within and Mental Hygiena. Is merked other than urnatic event, the M	2	Joseph	Edward Butler				Gladys	C	ofer	
Maryland d 2 should be flik th and Mental Hy 7 Is merked oth traumatic event		19a. Informant's Name/Relationship	(Type, Print)	19b. Me	eiling Address (Stre	et and Number or F	Rural Route Numbe	r, City or Town,	Stete, Zip C	lode)
CHNL	Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.	Catherine M. Clem			2 Mayhil	l Terrace	7			
0 - 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3	0.0	eca of Dis metery, o	sposition (Neme of cremetory or other p	lece)	Dete	20c. Location -	City or Tow	n, Stete
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altimore, mit. Pagas 1 a partment of Her portant: if item		21 Signature of Funerel Service Lic	psoon on		22. Name end Add	ress of Facility	DeVol Fun	eral Ho	me	
m ages		Michael	1) Callen	1	0 East De					20877
		23a. Part1. Enter the disease, or conshock, or heert failure. List only	nplications thet caused the death	. Do not	enter the mode of d	/Ing, such es cardi	ec or respiretory er	rest,		Approximete
Physician		snock, or neert failure. List on	y one cause on eech line.							Interval Between Onset end Deeth
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deal deal	Sici	Pert II. Other significant conditions	contributing to death but not resu	Iting in the	e underlying cause	given in Pert I.	23b. Did t	obacco use co	nirfbuta to	the cause of death?
I Records, P.O. The law requires that the de ate has been signed by the r page 2 should be detached	hy						101	res 2 No	3 Probe	ably 4 Unknown
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Records, he law requires the has been signed age 2 should be up a	8							en eutopsy med?	avei	re autopsy findings lable prior to
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The iaw ate has page 2	E						101	es 21 No	10	Yes 2□ No
	BeC	25. Was case referred to medical				26. Piece of D	eeth (Check only o	ne)		
	0	exeminer? 1 ☐ Yes 2 ② No	Hospital:	ER/Outpa	tient 3 DOA	Whor:	Home 5 N Resid		ner (Specify)	
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Division or Attending after death. Director: After Sin by the fune	#CS	3 ☐ Suicide 6 ☐ Could not	1 28e. Piece of Injury - At no	me, farm,	street, fectory, offic	8		Street and Numi	ber or Rural	Route Number,
Div affa	Certification:	4 Homicide	building, etc. (Specify)			City or Tou	m, State)		
spita nours neral		29a. Certifier 1 Certifying F	hysician: To the best of my know	vledge, de	eth occurred et the	time, date end ple	ce, end due to the	cause(s) and m	enner es sta	ited.
Ho Pur Jetah	edicai	(Check only 2 Medical Extrone)	miner: On the besis of examinet end manner stated.	on end/or	investigation, in my	opinion, deeth oc	curred et the time,	dete end plece,	and due to	the cause(s)
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	M	29b. Signeture end title of cartifier	-		29c. Lice	nse number		29d. Date signe	d (Month, D	ay, Year)
		1 Acous	a 20	~	- D4	+3083	3	Februar	7 19	1998
10		30. Neme end eddress of person who	completed cause of death (Item	23a) (Tvr					1	, , ,
		George A. Sotos,				#300	Rockvill	e. Mary	land	20850
S	tate	31. Dete filed (Month, Dey, Year)	36 Registrar's Signer	ure _		, , , , , , , , , , , , , , , , , ,	210 Grave V ale ale al	-,		
Regis		FEB 20 199	3 Julia Davidson	-April						

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death February 12, 1998 1830 Clement. Burch Sr. 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death St. Mary's 30246 Charlotte Hall Road Charlotte Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) 8. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Months Days Yrs. 214-16-7974 September 20,1920 Maryland Usuel Residence of Deceden 10c. City. Town or Location 10d. Inside City Limits 10b. County St. Mary's Maryland Charlotte Hall 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? II.S.A. 30246 Charlotte Hall Road 20622 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 1 Yes 2 □ No It Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Owner/Operator Gas Station 10th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Webster Burch Sr. Jessie Marie Tennison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 30265 Three Notch Road, Charlotte Hall, MD 20622 Patricia Jean Fisher/Daughter 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery 2/16/1998 Hollywood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Jardine P.O.Box 270, Leonardtown, MD 20650 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) desa. Due to (or as a consequenca ot) Due to (or as a consequence of): 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death?

Physician /Medical Examiner

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Division of Vital Records, P.O.

Physician

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10a. State

Director

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Completed

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Funeral

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner mant be notified at

permit. Pagas 1 and 2 should be filed within 72 hours after death Department of Haalth and Mentel Hygiene. Important: if Item 27 is marked other than "natural". or harmony or other trainment.

Baltimore, Maryland 21215-0020

with the Manylend

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical by Completed

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? 26. Plece of Death (Check only one) Other: 4 ☐ Nursing Home 5 K Residenca 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa ot tnjury - At home, tarm, street, tactory, office building, etc. (Specify) 4 | Homicide

1□ Yes No 27. Mapner of Death Naturel 2 Accident

29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature applifile of centifer

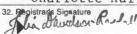
29c. License number 022102 29d. Date signed (Month, Day, Year)

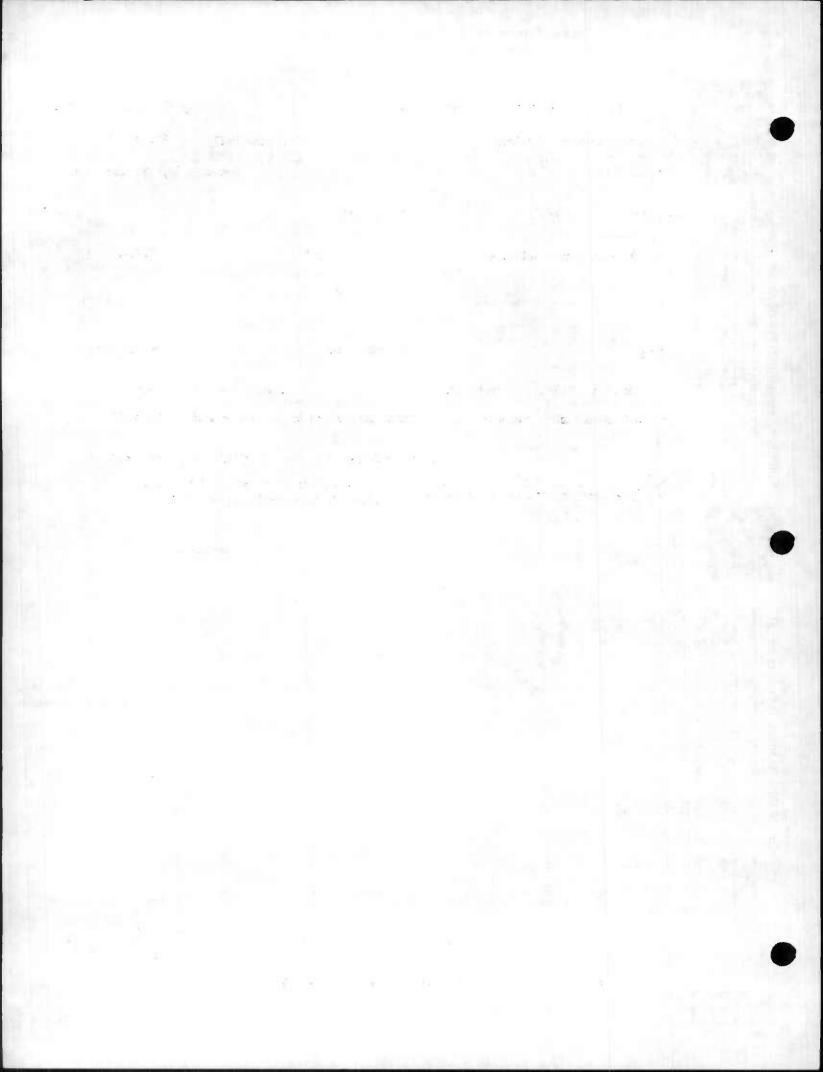
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

MD Mary Kramer 31. Date filed (Month, Day, Year) FEB 17

Charlotte Hall, MD 20622

State Registrar





State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dala of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death Month **Physician** Butler Myrtle Sarah February 16, 1998 12:10 AM /Medical 4a Facility Nama (If not institution, giva straat and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Bayside Nursing Center Lexington Park If Undar 1 Yaar | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Deys Hours 1 □ M 2 ■ F Yrs. Director 579-58-7454 85 May 16, 1912 Maryland Usual Residence of Deceden with the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar must be nothled at 1 ☐ Yes 2 No Director Maryland St. Mary's Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20779 Hermanville Road 20653 United States Pages 1 and 2 should be filed within 72 hours efter deeth nent of Haalth end Mental Hygiena.
nt: If Item 27 is marked other than "natural; or itema 23. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 █ No If Yes, Give Yeer or Dates: 14 Raca - American Indien Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Bleck, White, etc. 1 □ Navar Married 2 □ Married Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorcad Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiena. Elementary/Secondery (0-12) Coilege (1-4or 5+) Housewife N/A 17. Fathar's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Solomon Harris Sarah Faunterov 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Louise Barnes 20852 Hermanville Road, Lexington Park, MD 20653 Daughter other t Baltimore, 20b. Piece of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ■ Buriel 2 □ Cremetion 3 □ Removel from State injury or 4 ☐ Donetion 5 ☐ Other (Specify) Zion United Methodist 2/21/98 Lexington Park, MD 21. Signature of Bunarel Service Ligense 22. Neme end Address of Fecility any ir Brigsfield, Brinsfield Funeral Home, P.A. Edward N. Edward N. Brigsfield, Jr. M00052 22955 Hollywood Road, Leccase Pertl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 22955 Hollywood Road, Leonardtown, MD 20650 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final 2 days diseese or condition resulting in deeth) Theumonia Examiner Due to (or es e consequence of) Examiner Dementia certificate be axecuted Sequantially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest buniel-tran Due to (or es e consequence of): and physician s the buriel Box 68760. Physician/Medical Due to (or as a consequence of) 88 esn ò signed by the a 23b. Did tobacco uee contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Ware eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en autopsy Completed peen performed? has 1 Yes 280 No 1 ☐ Yes 2 ☐ No. certificate Division of Vital funeral director Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Top Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No this 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1. Naturai 5 Pending 1 ☐ Yes 2 ☐ No deeth. investigation 2 Accident after deeth Director: 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Pleca of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 4 Homicide 6 24 hours a Funerai C Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pieca, and dua to the ceuse(s) and menner es stated.

2 Medical Examinar: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date and piace, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) completely To the Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartifier 02 98 DR. M.A. Rahman, MD D50044 16 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

22650 Cedar Lane Court, Leonardtown, Maryland 20650

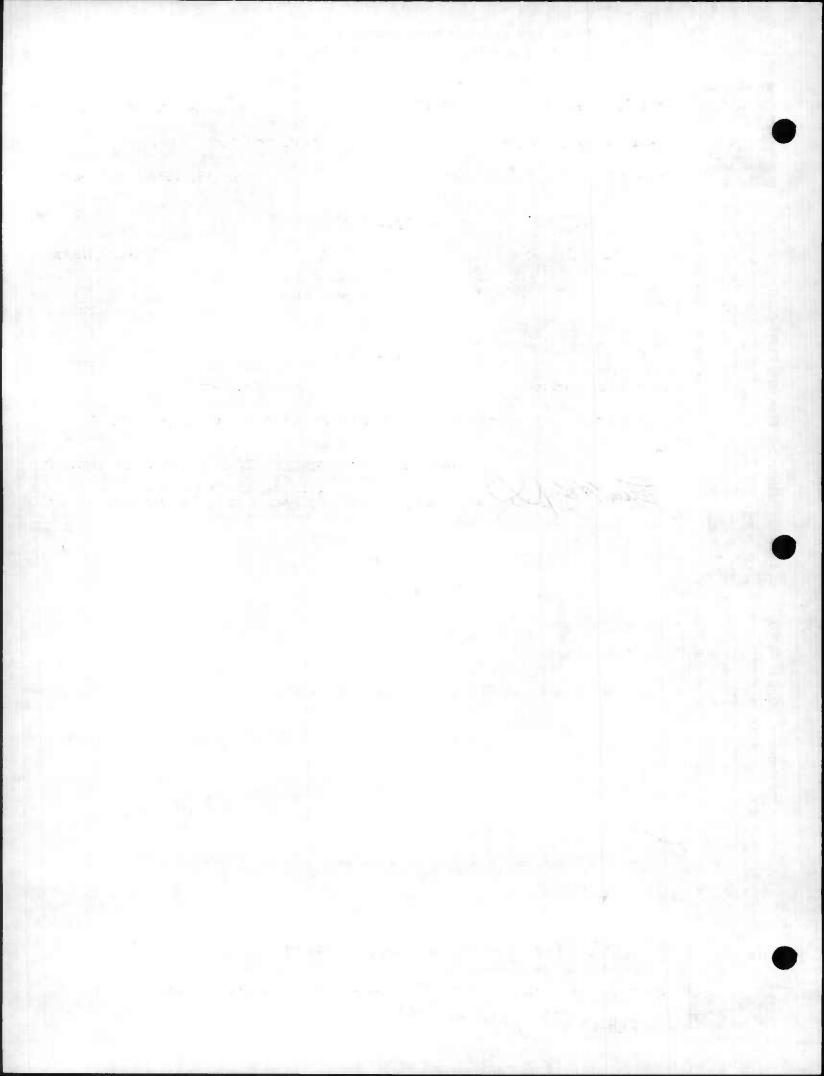
DHMH 16 Rev 6/95

Registrar

Mohammad Rahman, M.D. 22650 Ceda
31. Dete filed (Month, Day, Year)
32. Registrar's Signeture

FER 18 1998 Julia Murulum hardall

FEB 18 1998



State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Bernard Eugene Barnes 1998 February 12 5:55 PM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Undar 1 Year 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 1 M 2 F Yrs. Director 212-28-5770 March 7, 1930 Maryland Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ■ No Director Maryland St. Mary's St. Inigoes 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? P.O. Box 182 20684 United States Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) Race - American Indian, Black, White, atc. 1 ☐ Yes 2 ■ No If Yas, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ■ No þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8 Waterman Seafood 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Roland Barnes Mary Sewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Briscoe, Sister P.O. Box 182, St. Inigoes, Maryland 20684 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State St. Peter Claver 4 ☐ Donation 5 ☐ Other (Specify) 2/18/98 St. Inigoes, Maryland 22. Name and Address of Facility Brinsfield FuneralHome, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 20650 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEM Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consaquance of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wera autopsy findings eveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 3 Suicida 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifiai 🖎 Certifying Phyalcien: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature and title of contiller 29c. Licanse number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type Print) MECHANICSVILLE, MD. 20659

State Registrar

LEON BERUBE M.D. 9970LD ROUTE 2. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 18 1998

with the Maryland

deeth

28a-f show

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Deportment of Health and Mental Hygiena. Important: if Item 27 is marked other than "naturel", or ther any injury or other traumatic event, the Medical Exerci-

Physician /Medical

Examiner

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Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certification.

To the Hospital or Attar within 24 hours after des To the Funeral Director completaly filled in by th

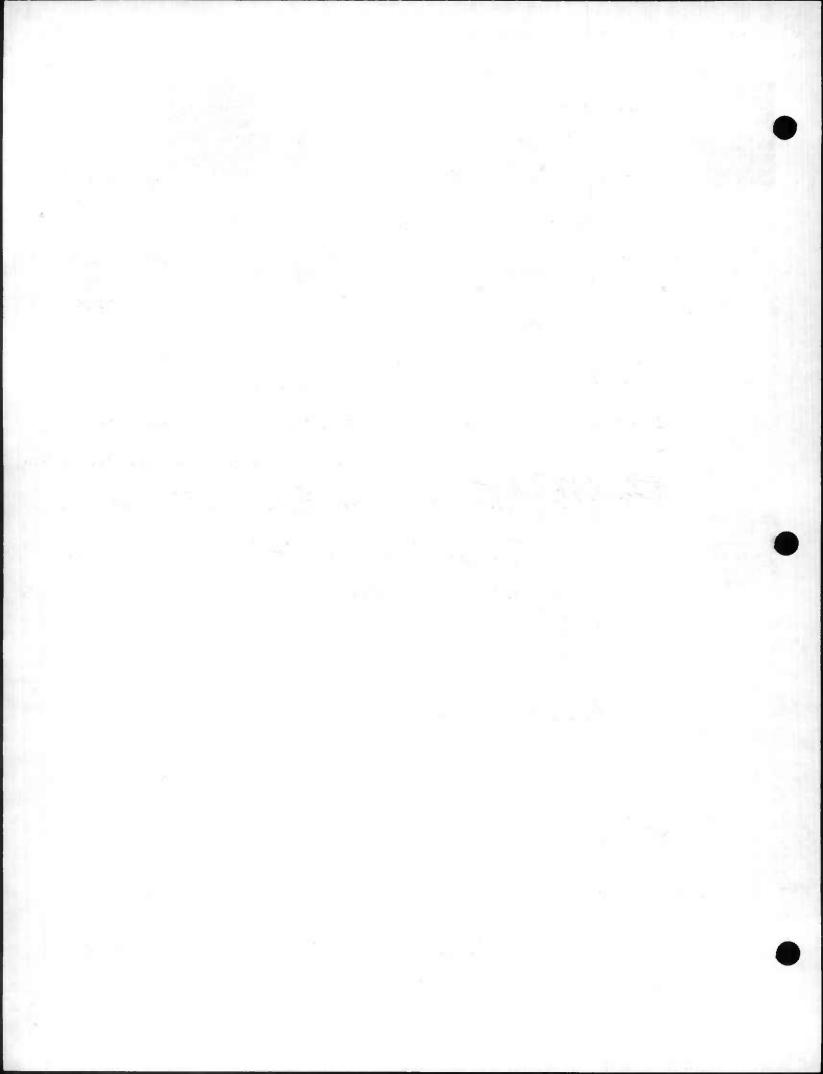
funerel

Box 68760.

BERNARD BARNES Division of Vital Records, P.O.

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3altimore, Maryland 21215-0020



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9	,	an	1. Decedent a realité (7 mai, micora, Last					2. Date of Death Month	Day Yo	3. Time of Death
F	/Medic				RGE	BROWN		February	1	
<i>_</i>	xamin	er	4e. Facility Name (If not Institution, giva				4b. City, Town, or L	ocation of Death	4c. County of I	Death
			The Memorial H				Easton		Talb	
	neral ector			7. Age (in) 79	rs. last bi	rthday) If Under 1 Yes Yrs. Months Day		8. Date of Birth (Month, Day, March 1	Yaar) 9.0, 1918	Birthplece (Stata or Foraigr Country) Maryland
pug :	ž		Usual Residence of Decedent 10a. Stete 10b. County	10c.	City, Tow	n or Location				10d. Inside City Limits
Aaryl	of a	ō								1 X Yes 2 □ No
eg :	200	Director	Maryland Talbot 10e. Street and Number		St. I	Michaels 10f. Zip Code		10	g. Citizen of Whe	at Country?
death with the Maryland	0 0			110 2011 1						
leath		era	Hambleton Village	113 Mitch	ell	St. 2166		necify Yes or No-	U.S.A	A. Americen Indian,
after a	al', or items 23a or 28a-f show Evaluation must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Noverced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	., 0,0.	If Yes, specify Co	f Hispanlc Origin? (Spuben, Mexicen, Puerto o Specify:	Ricen, etc.)	Black,	White, etc. Black
5-0 72 bo	natural,	Completed by	15. Decedent's Edu	cetion	16a	. Decedent's Usual Occ	upation	1	16b. Kind of Busin	ess/industry
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C 0 = 0	vent,	Be	17. Father's Neme (First, Middla, Last)					ne (First, Middla, M		
yla ould to	marked matic e	To	Richard Lee Brown				Joanna	Middlet	on	
lar 2 she end	e de de		19a. Informant's Name/Relationship (Ty	pe, Print)	19b	o. Mailing Address (Stre	et and Number or Ru	ral Routa Number,	City or Town, Sta	ata, Zip Coda)
ges 1 en	Jury or other		Richard L.Brooks 20a. Method of Disposition 1 Waurial 2 Crematlon 3 F 4 Donetion 5 Other (Specify) 21. Signature of Funerel Service Licens	emoval from State	h Place o	2304 Martin of Disposition (Nama of the consistency or other as Wemorial	Cemetery Fe	b. 21,199	8 St. N	20613 y or Town, State
m 535	any ir		1 Harrison &	Lenn	.0		E. Leonar			
Exam	dical niner	Examiner	23a. Pert1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	Unkno 5/P To	o (or as a	consequence of): KNEE consequence of):	REPLA	CEMEA		Interval Between Onset and Death 3 D Ay 3
φ <u>ξ</u>	for use es	Physician/Medical	resulting in deeth) Last	HYPERT	(or as e	consequence of):	DOVASC	ULAR		si= 7 10 year
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Thett	deta		DIABETES	MELLITU	\$.			1 Ye	8 2 No 3	Probably 40 Unknow
Joseph Page		Completed by						24a. Was an perform		4b. Were autopsy findings evailable prior to completion of cause of death?
R Sel	999 2	Eo						1□ Ye	s 2 00	1 ☐ Yes 2 ☐ No
Vital Fiction: The	tor, p	0	25. Was cese referred to medicet				28 Place of Dea	th (Check only one	()	
of Vita Physician:	direc	ToB	examiner?	ospital: 15 Inpatient 2	ER/O	utpatient 3 DOA	Whos:	ome 5 Resider		Specify)
Phys	eral		27. Menner of Deeth	28e. Date of Injury	28b.	Time of 28c. In		28d. Describe ho		opeony
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Division or Attending effer death.	d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, fa	arm, street, fectory, office	е	28f. Location (Str. City or Town,	eet and Number (Stata)	or Rural Routa Number,
Division (To the Hospital or Attending F within 24 hours efter death to the Funeral Director After	to the runeral prector; After this certificate its completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best of my lier: On the basis of exam and manner stated.	knowledge inetion en	e, death occurred et the d/or investigation, in my	time, date end piece, opinion, death occur	end due to the ce red et the time, da	use(s) and manne te and place, end	er as stated. I due to the ceuse(s)
Vithi To th	COM	M	29b. Signature and title of certifier	Othe			nse number 9565	29	Peb. 16	
В	Stat		30. Name and address of person who continues and address of person who continues and address of person who continues and address of person who continues are address of person	OTTER	. 4	(Type, Print) OC MAN	DELG	EAS	STO N.	MD

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Electh Month **Physician** 02 John Henry Beck, Sr. 02 98 06:10 p.m. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Denton, Maryland Caroline Caroline Nursing Home, Sociel Security Number 6. Sex Inc. 7. Aga (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Yaer) Birthplaca (State or Foreign Country) **Funeral** Months 10XM 2□ F 84 Yrs. Director 220-07-7243 Aug. 13, 1913 Maryland Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelth and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example must be purified at ODE. 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County XXYes 2□No Director Maryland Caroline Denton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1014 E. Gay Street USA Funeral 21629 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Black, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 X Never Merried 2 Married 1 ☐ Yes 2 XNo Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest greda completed) 16a. Decedent's Usuei Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 6th Foreman Campbell Soup Co. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Surnama) Be 9 Broaden T. Beck Nancy E. Henry 19e. Informant's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) John H. Beck, Jr., Son 1014 E. Gay Street, Denton, Md. 21629 20b. Placa of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ₺ Burlal 2 □ Cremetion 3 □ Ramoval from Stete 4 ☐ Donation 5 ☐ Other (Specify) 2/7/98 | Marydel, Md. Mt. Zion Cemetery 21. Signeture of Funarel Sarvice Licenses 22. Nama and Addrass of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601 23a Part 5 ha disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock or heart fellure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physiclan** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) neumanea Examiner Examiner attending physician and for usa as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai that initiated events resulting in deeth) Last Due to (or es a consequance of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Insulin dependent diabetes mellitus 1 Yes 2 No 3 Probably 4 Unknown þ been si 24b. Were autopsy findings evalleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? Prostate carcinoma s cartificata has t director, paga 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 45 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Affar 1 Neturel 5 Pending Invastigetion s after de. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completaly filled in by the 3 Sulcide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date end plece, end due to the cause(s) end menner as steted.

2 Medical Examinar: On the basis of axaminetion end/or invastigetion, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) 29c. License number 29b. Signeture end titla of certifier. 29d. Data signed (Month, Day, Year)

D47534

902 Market Street, Denton, Maryland 21629

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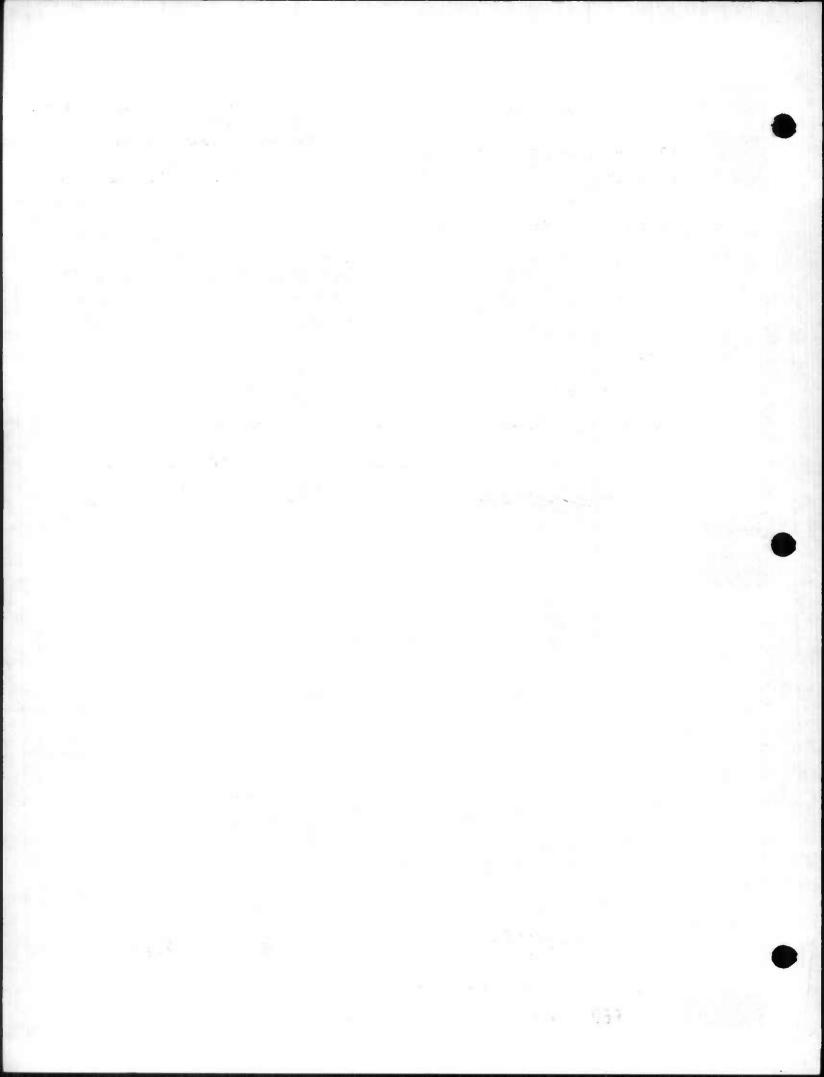
State Registrar 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Ragistrar's Signature

wha Davidson

Dr. Wafik Zaki
31. Dete filed (Month, Day, Year)

FEB 11



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Deeth **Physician** Brawner Kandolph JANUARY /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 7. Age (In yrs. lest birthday) | H Under 1 Year | If Under 24 Hrs. | 8. Date | 15 Yrs. | Months | Days | Hours | Min. | 1 (Months | Months PENINSULA REGIONAL MEDICAL CENTER WICOMICO 5. Social Security Number 6. Sex 10 M 2□ F 8. Date of Birth (Month, Dey, Year) **Funeral** 218-16-3/49 Usual Residence of Decedent Director June 17, 1922 maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director Mary and Summerset 10g. Citizen of What Country? 21867 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 PYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Health end Mental Hygiene. em 27 is marked other than College (1-4or 5+) ree Purity Bacon Co, 18. Mother's Name (First, Middle, Meiden Sumethe) 10 Laborer 17. Father's Neme (First, Middle, Lest) Merril Brawner Blanch Lancaster 19a. informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Cecelia Brawner (wife) e) 8084 Gill's Lane, Upper Hill Md. 21867

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

20c. Location - City or Town, Stata or other t 20a. Method of Disposition 5 1 Buriel 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Johnson tunily Cemetary 1-27-98 Upper Hill, md 22. Name and Address of Facility Bennie Smith Funeral Home Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errord, Approximate or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting In death) /Medical mumonitis Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760, Physician/Medicai Due to (or es a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown mostate Division of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 3 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Naturel s efter death. 1 Yes 2 No illed in by the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one)

State Registrar 31. Date filed (Month, Day, Year) FEB 11 1998

29b. Signature and title of certifier

RODNEY

A- WENRICH 100 POWER ST. 32. Registrar's Signature Julia Davidson-Randalle

odney a. Wenneh. M.D.

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29c. License number

SALISBURY

29d. Dete signed (Month, Dey, Year)

JAN. 22, 1998

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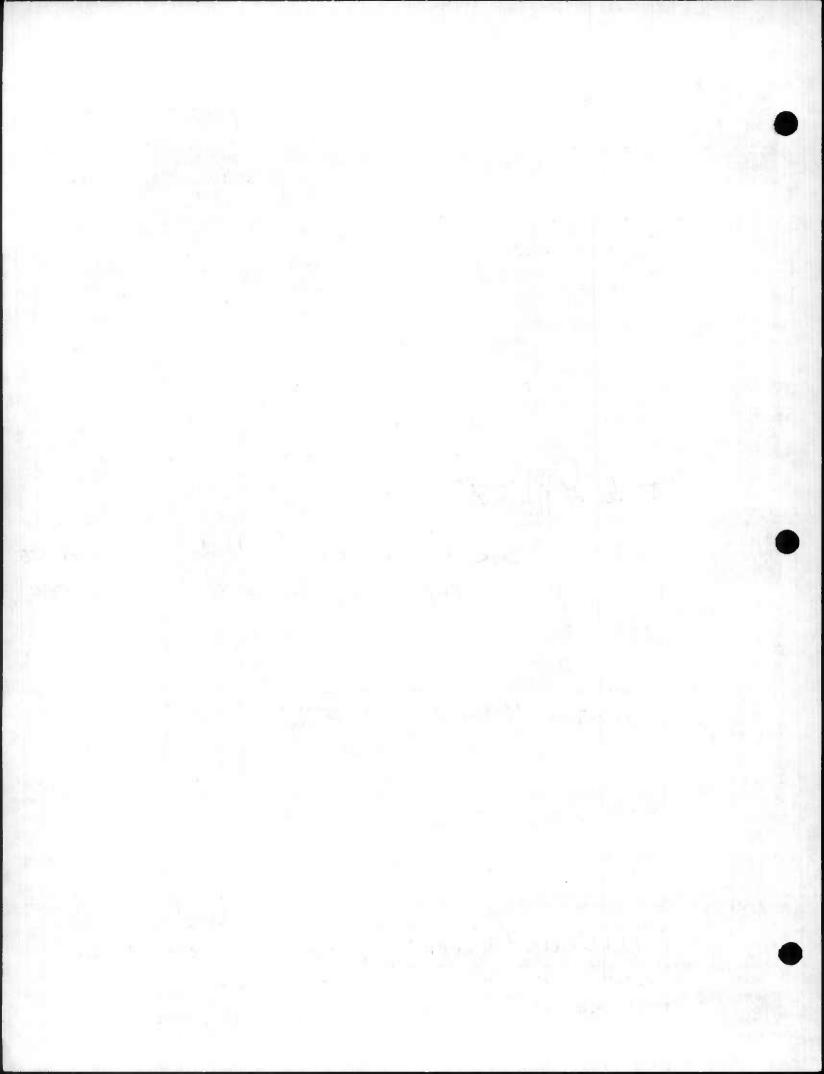
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Examir Funeral Director	,	215-26-9808	TREET	yrs. last birthday) Yrs.	If Under 1 Year Months Deys		ND S. 8. Date of Bi	th 4c. County ALLE irth ey, Year)	y of Death
show		Usual Residence of Decedent 10a. Stete 10b. County	100	c. City, Town or Loc	cation				10d. Inside City L
Se-f sh	ctor	MARYLAND ALLEGA	NY C	UMBERLANI	D				1 Yes 2
23a or 2	al Director	10e. Street and Number 1106 FREDERICK S	TREET		10f. Zlp Code 215	02		U.S.A.	Whet Country?
al', or items 23a or 28a-f shov Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decadent Ever Armed Forces? 1 ☐ Yes ②∑No If Yes, Give Year or Dates:	if	Vas Decedent of Yes, specify Cut	Hispanic Origin? (pen, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	Ble	ca - American Indian, ick, White, etc.
ene. then "netur the Medical	Completed	15. Decadent's Ec (Specify only highest gre Elementary/Secondery (0-12)	ducation de completed) College (1-4or 5+)	16e. Decedo (Give la life. D COLUMBI	ent's Usual Occu kind of work done O NOT use retire A GAS CO	pation during most of wo ed) OMPANY	orking		E OPERATOR
marked other marked other imatic event, t	To Be C	17. Fether's Neme (First, Middle, Last) CALVIN PERRY BRU				1 - 2 - 2 - 2	ame (First, Middle		ne)
S T		19a. Informant's Name/Relationship (I				t end Number or R	Rural Route Numb	per, City or Town,	, State, Zip Code) YLAND 21502
t: If item y or othe		20e. Method of Disposition 1 Burlel 2 Cremetion 3 4 Donetlon 5 Other (Specify	Removal from State	b. Place of Dispos	ition (Neme of etory or other pla		Date	20c. Location -	- City or Town, State AND MARYLAND
Depermentimportant: any injury		21 Signature of Funeral Service Ligen	4	22.	Name end Addr				IND HARTLAND
ysician fedical aminer		Immediate Ceuse (Final disease or condition resulting in death)	· CARDI	AC A	000	7			Onset and Deal
cian end buriel-trensit	al Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	b. CORUNA	to (or es a consequ	ienca of): 2TERY	1 DISE	PASE		10 YEA
f the attending physician end ched for use es the buriel-trensit	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	b. CORUNA Due to	to (or es a consequ lo (or as e consequ o (or es e consequ	ence of): 2 TERY ence of):	DISE	23b. Did	tobacco use co	
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The Enneath of the Control of the Co	ledical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Part tt. Other significant conditions conditions conditions are sequentially conditions. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation Suicide 4 Homicide 6 Could not be determined.	b. CORONA Due to c. Due to d	to (or es a consequence of the c	ence of): 2 T 2 V ence of): ence of): derlying cause given the first security of the	ven in Pert i. 26. Piece of De her: 4 \(\text{Nursing } \) No me, date and place appinion, deeth occurse number	1 □ 24e. Was performed at the time,	Yes 2√ No one) dence 6 □Oth how injury occurs Street end Numb wm, Stete) cause(s) and ma date end placa, a	antribute to the cause of de 3 Probably 4 Unk. 24b. Were autopsy finding evallable prior to completion of cause of death? 1 Yes 2 No No let (Specify) are or Rural Route Number,



State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer **Physician** RUTH CLAUDINE BOSLEY 18, 1998 10:30 AM FEBRUARY /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner ALLEGANY MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 8. Date of Birth (Month, Dey, SEPT 12 Birthplece (State or Foreign Country) **Funeral** 1□M 2XXF Months Days Hours 216-66-0553 Yrs. Director 87 SEPT W. VA. Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours aftar death with the Manyland neat of health and Mantla Hyglane.
nnt: If them 27 is merked other than "natural", or hems 23a or 28a-f show any or other traumatic event, the Mandral Exprinter man be notified at any or other traumatic event, the Mandral Exprinter man be notified at 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits MARYLAND ALLEGANY CUMBERLAND Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1032 FREDERICK STREET 21502 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 X No Specify: Be Completed by Specify: WHITE 3 ₩ Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grede completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 11 HOUSE KEEPER HOUSE KEEPER altimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) GRAYSON HAINES 0 ALBERTA MILLER 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) JANICE STRAW DAUGHTER 12814 OLD CHURCH LANE N.E. CUMBERLAND MARYLAND 21502 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment Important: If any Injury or SUNSET CEMETERY FEB 20 1998 4 ☐ Donetion 5 ☐ Other (Specify) CUMBERLAND MARYLAND ure of Funeral Service Lice 22. Name end Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heer failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician Immediate Ceuse (Finel disease or condition resulting in death) e. Anoxic encephalopathy 8 hours Examiner Due to (or es a consequence of): Examiner Cardiac arrest 8 hours for usa as tha buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Ihet initieted events resulting in death) Lest Due to (or as a consequence of): i or Attanding Physician: The law requires that the death cartificate be axect after death.

Director: After this cartificate hes been signed by the attending physician and RUTH BOSLEY Division of Vital Records, P.O. Box 68760, Ruptured intra-abdominal viscus 12 hours Physician/Medical Due to (or es e consequence of): datached Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown 1 Yes Old age, cardiomyopathy þ 90 24b. Were eutopsy findings evailable prior to completion of cause of deeth? director, page 2 should Completed 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient Certification: To 2 ER/Outpetlent 3 DOA the funaral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1. Naturel 5 Pending investigation Injury 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital crititying Physicien: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and manner es stated.

Discretifying Physicien: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner es stated.

Discretifying Physicien: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner es stated. Medical 29a. Certifie complately (Check only one) end menner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 560 **FEBRUARY** 1998 D19318 30. Name end eddress of person who completed cause of deast-(ffern 23a) (Type, Print)

517 OLDTOWN ROAD, CUMBERLAND, MD

32 Registrar's Signature

21502

DHMH 16 Rev 6/95

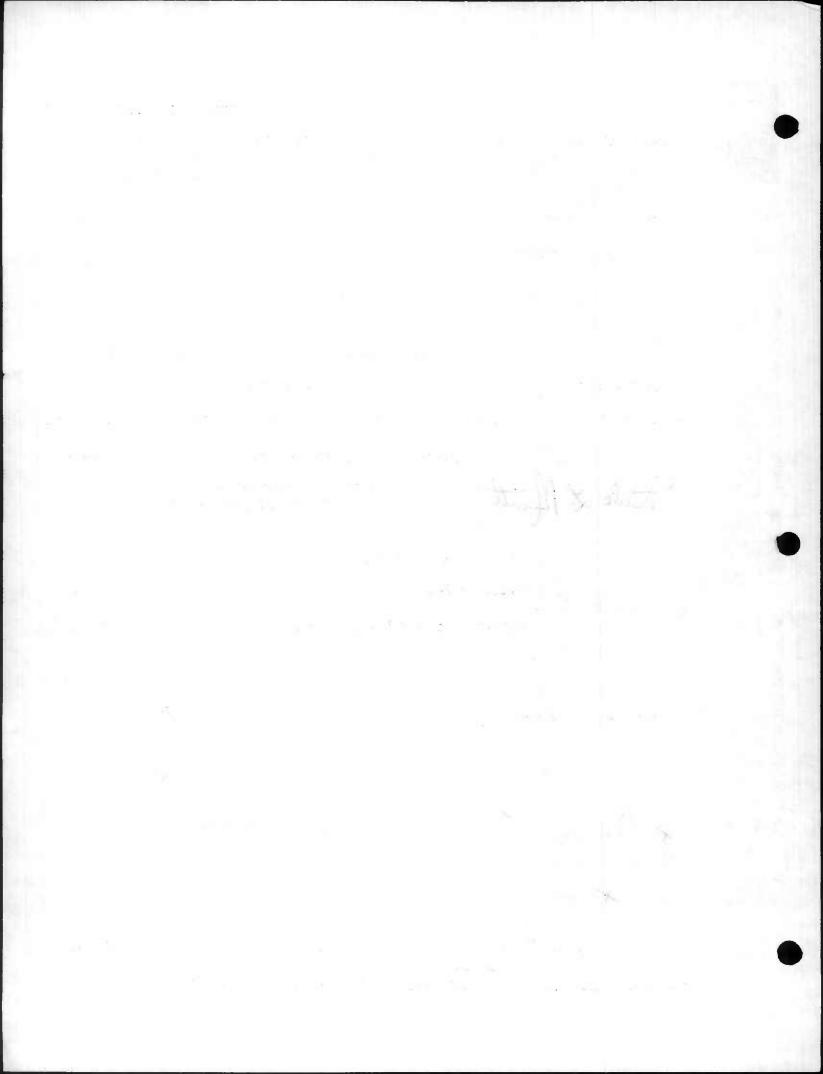
State

Registrar

DR. N.A. RANJITHAN,

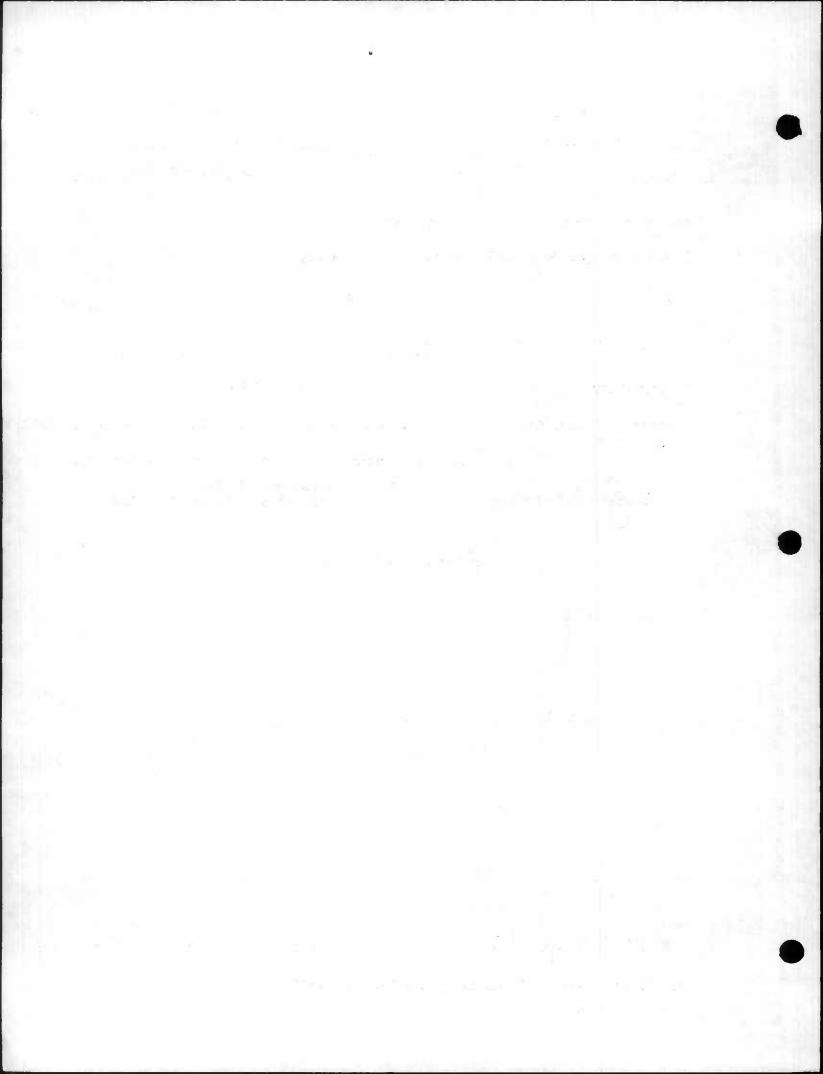
8 1998

31. Date filed (Month, Day, Yeer)



State of Maryland / Department of Health and Mental Hygiene 98 0674 (

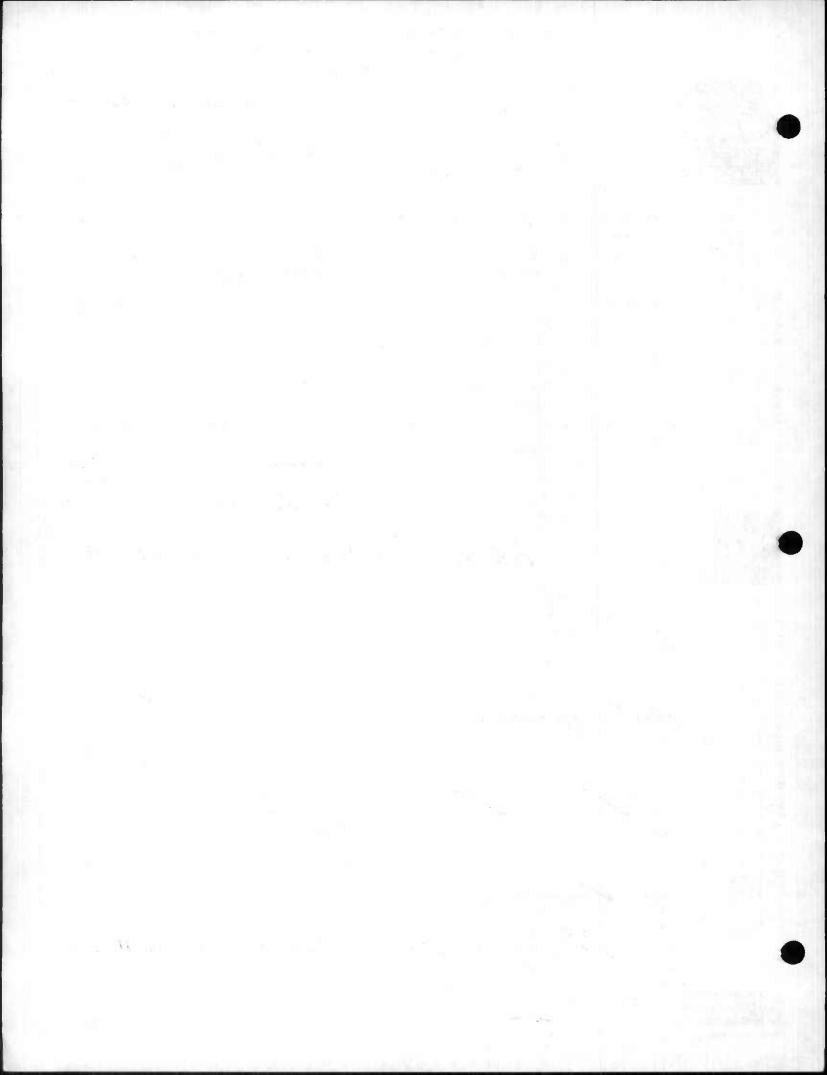
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		Memorial Hosp	ita1						Cumb	erla	and	A	llega	anv	
uneral		5. Social Sacurity Number	6. Sex		7. Aga (In)	rs. last birth	day) If Ur Mont	hs Deys	If Under	24 Hrs.	8. Date of Bir	h			ce (Stata or Fo
irector	218	-48-9100	1]M 2 X]F	86	5 Y	rs.	50,0			Jan.26,	1912		aryl	
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0 0	늅		_	3 5		10	101.	Zip Code				10g. Citizen of Whet Country?			
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Rema Inter m	5	11. Maritel Status 1 ☐ Nevar Married 2 ☐ Ma		Armed Fo	orces?	10,5.	If Yes,	specify Cut	an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	No- 14. Rece - Am Bleck, Whi			
l', or	by Funeral Director	3 Widowad 4 □ Divorce		If Yes, Gi Year or D	ve		1□Ye	s 2XXNo	Spacify:			S	pecify:		4
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uma		19e. Informant's Name/Relation	ship (Ty)	pe, Print)		19b. I	Meiling Add	ress (Stree	1		el Route Numbe	er, City or T	own, Ste	ite, Zip C	code)
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rtment o rtant: If njury or		20e. Method of Disposition				b Place of [Disposition /	Neme of			Date	20c. Loca			
		1 Aburlel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Temperatury or other pleca) Dry Run Cemetery Feb.14, 98; Bitting										ger.	MD		
		21. Signature of Funerel Sarvice		96	(-y roll	22. Name	end Addr	ess of Fecili	tv					
any l		N. X. X	Der	ma	.)		Newm	an Fu	neral	Hom	es, P.A		077	26	
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sician		23a. Part1. Enter the disease, o shock, or heart failure. Lis	t daily on	ne ceuse on a	each line.										
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edical		Immediate Ceuse (Finel					11/1				, , , , , ,			- Ir	ntervel Between
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State of Maryland / Department of Health and Mental Hygiene

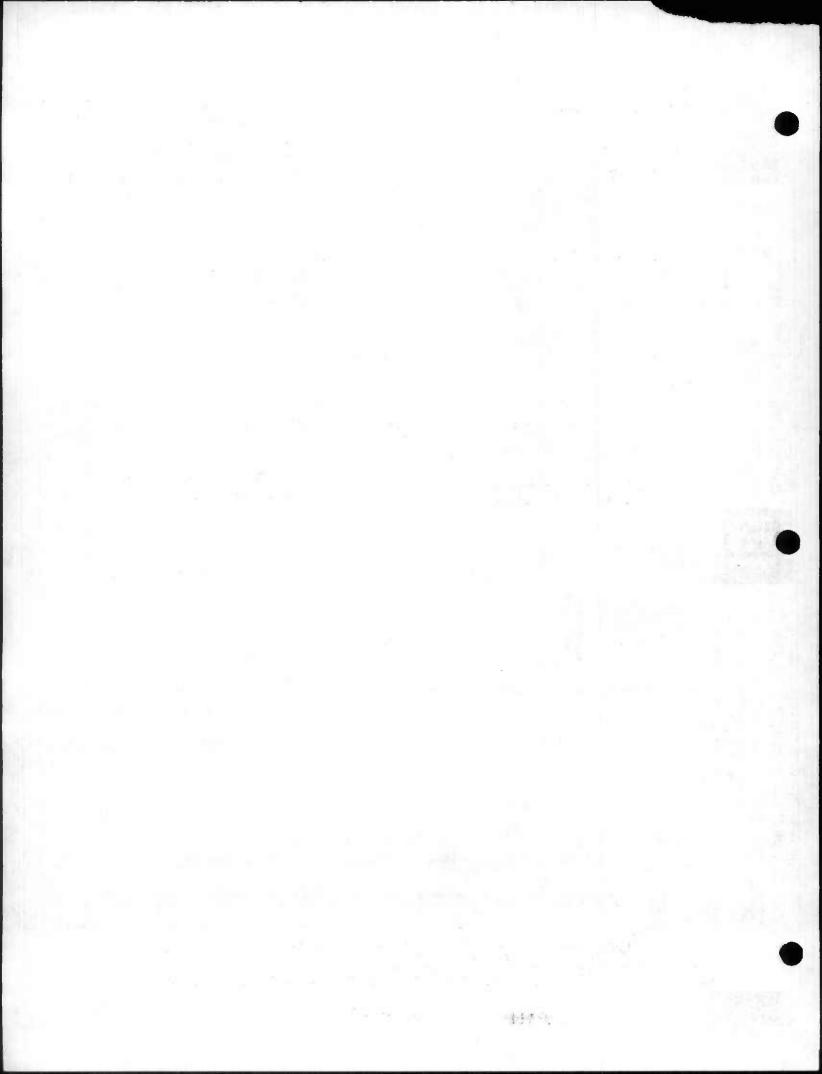
Certificate of Death

						Certific	ate of	Death		Reg. No.) U	0/41
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	Physic /Medi		SaraH E	lizabeth	BI	OWN			FEBRUA	ARY I'l,	1998	2010
	Exami	ner	4e. Facility Neme (If not institution, giv						or Location of Dec		y of Deeth	
L			Sacred Hear	+ Hospi	tal		day 1 Van	Cumbe	rland	All	logai	NY
10	Funeral Director		5. Social Security Number 5. Social Security Number 2/5-/2-2045 Usuel Residence of Decedent	ex 7. Age (In yi	7 9	Yrs. Monti	ns Deys	Hours N	Hrs. 8. Dete of B (Month, L NoV;	17th Bey, Yeer) B, 1918	9. Birthp Cour	plece (State or Foreigntry)
	yland wow		10e. State 10b. County			or Location					1	Od. Inside City Limit
	Mar	to	maryland Allega	ay c	CUM	berla	Nd					1 NYYes 2□N
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Mosical Engineer must be notified at	by Funeral Director	10e. Street end Number 509 Greews	Street		10f.	Zip Code	502		10g. Citizen of US		ntry?
	daa	iner	11. Maritel Status	12. Wes Decedent Ever in Armed Forces?	U,S.	13. Wes De	cedent of	Hispenic Origin?	(Specify Yes or Nuerto Rican, etc.)	lo- 14. Re	ce - Americ	
21215-0020	"natural", or it		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			2 No		,	Specil		lack
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Maryland	should b nd Ments marked	F	19e. Informent's Neme/Reletionship (. Meilina Addr	ess (Stree		Rural Route Num		. Stete. Zic	Code)
	s 1 and 2 should be filed f Health and Mental Hygi tam 27 la marked other other traumatic event,		mrs. Helen Edwa									
ore,	of Hee Itam othe		20a. Method of Disposition	20b	. Plece of	Disposition (I	Vame of	ace)	Febr	20c. Location		
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Bal	pemit. Pag Department Important: I any injury o		21. Signeture of Funeral Service Licar Ernest a,	4 4		Leas	SUPE	- Stein	V FUND	ral Hui	me:	230 d. 2150
10000	Physician /Medical Examiner	er	23e. Pert1. Enter the disease, or com shock, or heert failura. List only Immediata Ceuse (Finel diseasa or condition resulting in death)	e. Ends Hy		1					A	Intervel Between Onset end Deeth 4 4 25
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D C		on:	27. Menner of Deeth 1 ☑Natural 5 ☐ Pending	28e. Dete of Injury (Month, Dey Yeer)		ime of njury	28c. Inju		28d. Describe	how Injury occu	rred	
Division	or Attendant fler dant Mrector: in by tha	Certification:	2 Accident investigation 3 Sulcide 6 Could not be determined		home, fa	m, street, fec		Yes 2□No		(Street end Num. own, State)	ber or Rurs	al Route Number,
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State of Maryland / Department of Health and Mental Hygiene QQ 00

					Certificate		F	Reg. No.	0 (10/42
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	dical			JUM			Februar	ry Ï1,	1998	400 Am
	niner	4a. Facility Nama (If not instituti	on, giva straat and numbe	or)		4b. City, Town, or L	ocation of Daath	4c. County	of Death	
	4	89 Swantamont 1				Swanton			arret	t
Funer	200	5. Social Security Number	6. Sex 7. / 1 ☐ M 2)∑ F	Age (In yrs. last b	Months [Year If Undar 24 Hrs. Days Hours Min.	8. Data of Birtl (Month, De)	h /. Yaar)	9. Births	placa (Stata or Foraig
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Ma Ma	Ş	MD Ga:	rett	9	Swanton					1 ☐ Yas 2 🖺 No
th th	Director	10e. Street end Number			10f. Zip Co	oda		10g. Citizan of	What Cou	ntry?
th wi	<u>a</u>	89 Swantamont 1	Road			2156↑			U.S.A	١.
dea	Funeral	11. Maritai Status	12. Was Deceder Armad Forces		13. Was Dacedan	t of Hispanic Origin? (Sp Cuban, Mexican, Puarto	ecify Yes or No-		e - Americ	can Indian,
ine, intelligible filed within 72 hours after death with the Manyland of Health and Mental Hygiena. The state and Mental Hygiena. The state and Mental Hygiena other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examine man be notified at	ò	3 ☐ Widowed 4 ☐ Divorce	rriad 1 ☐ Yas 21X] No	1 ☐ Yas 2 🖸		Hican, etc.)		ck, White, y: Whi	
3-C 72 h 72 h 72 h) je	15. Decede	nt's Educetion ast grada completed)	168	Decedant's Usual C	occupation fona during most of work	vina	16b. Kind of B	usinass/în	dustry
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S she and and		19e. Informant's Name/Relation	ship (Type, Print)	19	b. Meiling Addrass (S	treet and Number or Rui	ral Routa Numbe	r, City or Town,	Stata, Zip	Code)
end saith		Wesley W. Blum,	Husband	8	9 Swantam	ont Rd., Sw	anton.MI	21561		
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Datimore, bemit. Pages 1 er Department of Hea mportant: if Item 3 ny injury or other		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (а		m. Gardens2	/13/98	Oaklan	d. Ma	rvland
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or Attending Physicien: The law requires the deed death. Director: After this certificate has been signed in by the funeral director, page 2 should be a	Certification:	27. Mennar of Deeth 1 Natural 5 Pandi 2 Accident Invast	28a. Data of Inj (Month, Digation	ay Year) 28b.	Time of 28c.	Injury et Work? 1 Yas 2 No	28d. Dascribe ho	ow injury occur	red	
or Attend efter death Director: /	flea	3 ☐ Suicida 6 ☐ Could	not be 28a. Place of Ir	njury - At home fa	arm, streat, factory, of		28f. Location (SI	treet and Numh	er or Rura	il Routa Number
din to the	- T	4 ☐ Homicida Getarri	building, e	ic. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town			
To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) Certifyli	ng Phyelclan; To the best Examiner: On the basis	ot axamination an	a, death occurred et the	na time, date end place, my opinion, deeth occurr	and due to the cared at tha tima, d	ausa(s) and me eta and place,	nner as st	etad. o tha cause(s)
ithin or the complete or the c	Me	29b. Signature and title of certifie	and mannar s		290 11	cense number	2	9d. Date signe	d (Manth	Day Year)
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		- Irung	ares al	1 ku	-17	D26650		2/11/9	8	
	1	30. Nama and address of person								
	10	Margaret A. K		13079	Garrett Hi	ghway Oakla	and MD 2	1550		
	tate	31. Dete filed (Month, Day, Year,	32. Regist	rer's Signature	131					
Regis	trar	FEB	1 9 1998	abo, eller	cartinols.					
WHILL IS DON S	me									



Amended # 40, nds, Pleas 2/20/98, Allegany County Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middia, Last) 2. Data of Death 3. Time of Death **Physician** Month Philip D. Cole 02 1998 16 /Medical 4a. Facility Name (If not Institution, give street and number)

Moran Mamanor Nursing Home 4b. City. Town, or Location of Death 4c. County of Deatl Examiner Westernport, Md Allegany If Under 1 Year H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sax 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplaca (State or Foreign Country) 1□M 2□ F 217 01 9784 Yrs. 88 Director Maryland Aug6, 1909 Usual Residence of Dacedent 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at Y□Yes 2□No Director Mineral Piedmont Wv 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 77 Erin St Piedmont Wv U.S.A.

14. Race - American Indien,
Black, White, etc. Funeral 26750 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examines, once. 1 □ ★es 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ Mo Specify: p Specify: 3 ₩ Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Loader 12 Paper 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Harry M. Cole Elizabeth M. Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Lowell Taylor, Sr. Rt 4 Box 32F Keyser, Wv 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2/19/98 tX Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens Keyser, Wv 21. Signatura of Funerai Service Lic 22. Nama and Address of Facility Fredlock Funeral Home P.O. Box 4, Piedmont, Wv 23a. Part1. Enter the disease, or complications that caused the death. She flet anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximata Interval Between Onset and Death **Physiclan** stratible Conjective Here Failure /Medical Immadiata Cause (Final 2 vecely disease or condition resulting in death) **Examiner** The law requires that the deeth certificate be executed hysician end the bunel-tran Sequentially list conditions, if any, leading to Immediata cause. Enter Underlying Couse (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ∮ Unknown Records, b we mofficin Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death? certificate 1 ☐ Yes 2 ☐ No Vital Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 2 1 Yas 2 No of this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Division T/ Naturai 5 Pending s efter deeth.

I Director: Aff
ad in by the ful invastigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ò To the Hospital o within 24 hours eff To the Funeral DI completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and titla of certifian 29c. License number 29d. Date signed (Month, Day, Year) 021244 21.7158 30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print)

Frostburg Plaza

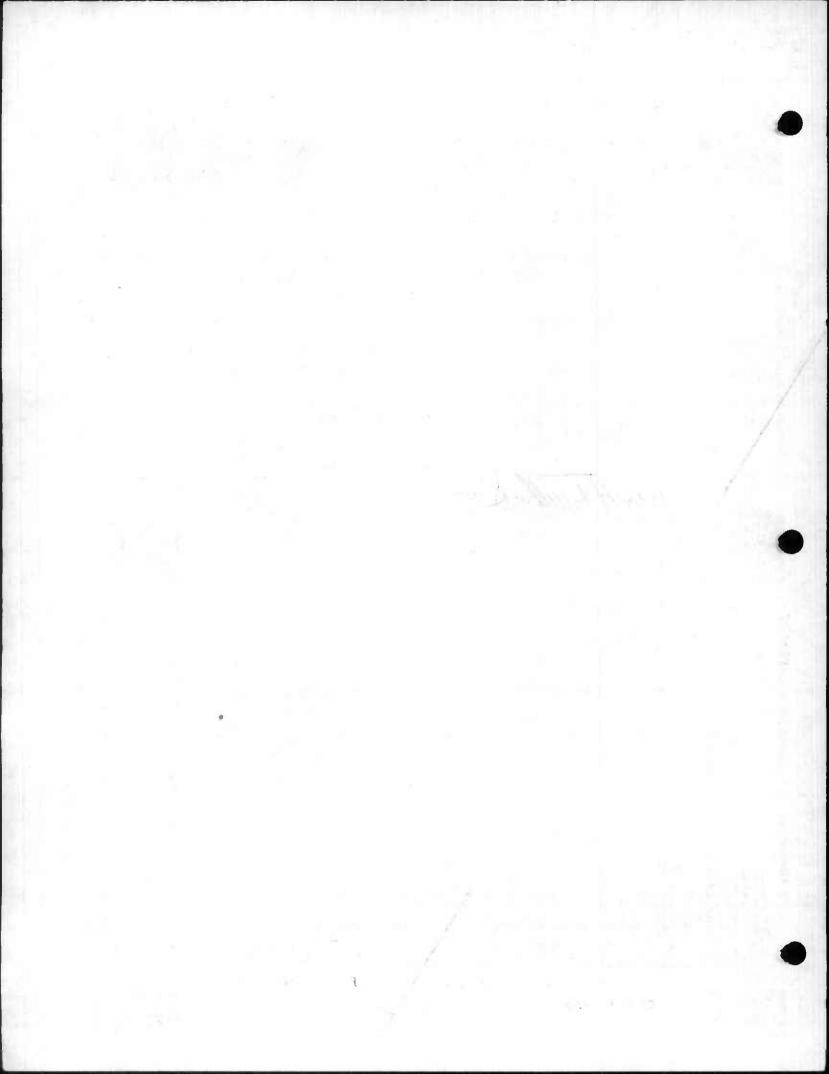
32. Ragistrar's Signature

Frostburg MD21532

State Registrar Jesus Tan.

DHMH 16 Rev 6/95

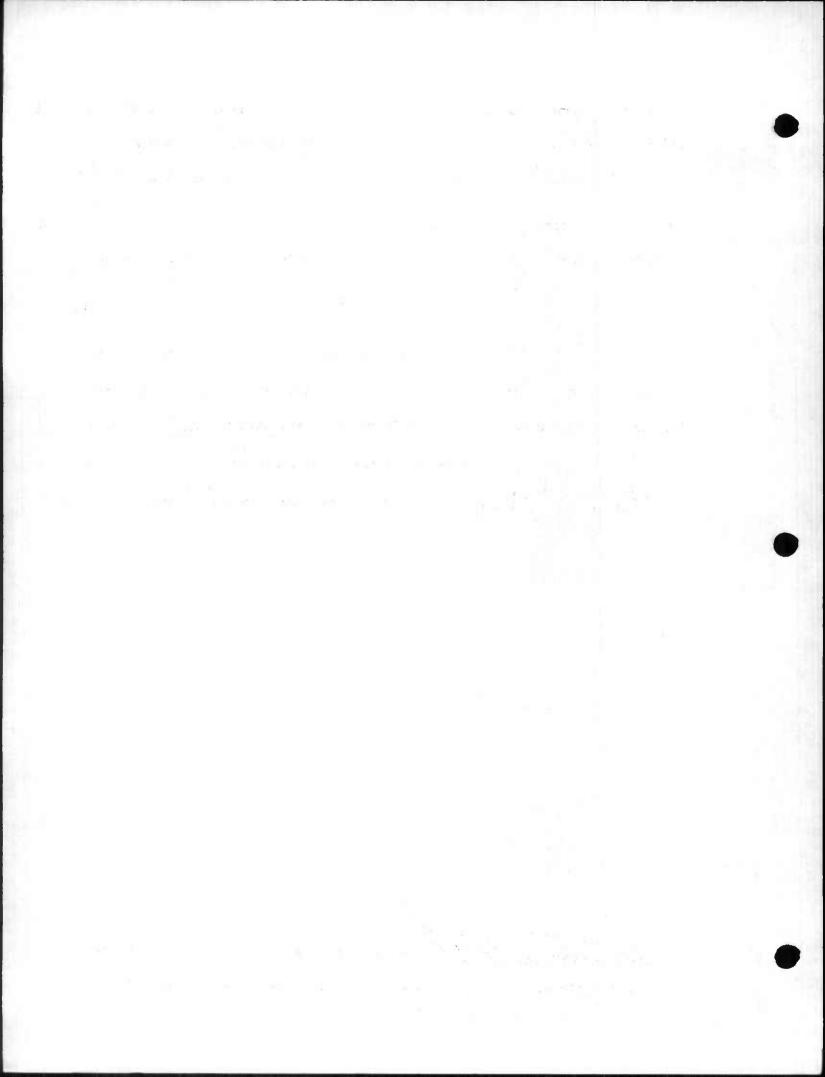
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State of Maryland / Department of Health and Mental Hygiene 2 0671.1.

					Certifica	te of	Death		Reg. No.	00	1 -4 -4
Physic	ian	Decedant's Nama (First, Middla, L.	·					2. Date of De Month		Year	3. Time of Death
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Exami	ner	4e. Fecility Neme (If not Institution, gi					4b. City, Town, or L			Sample S	
		12309 Pueblo Road			M I be de		Gaithersb			0	
Funeral Director		5. Social Security Number 6. 556-44-4964 Usuel Rasidance of Dacedant	Sex 7. Ag 1 □ M 2 □ F	61	Yrs. Months	er 1 Yaer s Deys		8. Data of Bir (Month, De Oct. 1	th ay, Year) 5,1936	9. Birthpia Country Calif	ca (Stata or Foraign y) Ornia
72 hours effer death with the Maryland natural, or items 23s or 28s-f show deal Examiner must be notified at		10a. Stata 10b. County		10c. City, Tow	n or Location					100	d. Insida City Limits
Ma Ma	5	Maryland Montgom	ery	Gaith	ersburg						1 ☐ Yas 2 ☐ No
97.28	ě	10e. Street end Number				ip Coda			10g. Citizan of	What Countr	y?
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Depertment of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Examinst must be notified at 2008.	by Funeral Directo	11. Marital Status 1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Armed Forcas? 1 X Yes 2 1 If Yas, Giva	No1/6/55	13. Was Dece If Yas, spe 1 \(\superscript{\text{Yas}}\)		Hispenic Origin? (Spean, Maxican, Puarto Specify:	pecify Yas or No Rican, etc.)	1.000	ick, Whita, at fy:	c.
a di	D D		Year or Datas 1	2/20/38	16a. Decedant's Usual Occupation			,		Wh	
- 4	Completed	15. Decedant's E (Specify only highast gi	ada completed)	16a.	(Give kind of w	vork dona	pation during most of work d)	king	16b. Kind of 8	Susiness/Indu	stry
than	F	Elementary/Sacondary (0-12)	Collega (1-4or 5		ivil Eng						o
Hygi He		17. Fathar's Nama (First, Middla, Las		0.	LV3.1 Dite	Since		a (First, Middla			6
sed o	Be C	Aaron Dana	Clary				Orvilla	Anı			n
nari mari	2	19a. Informant's Name/Raletionship		19h	Mailing Address	ss /Street					
trace		Hedy Diaz Clary,	Wife								
Hee		20a. Mathod of Disposition	MILE	20b. Placa o	f Disposition (Na	ama of		Data			
of all		1 Burial 2 Cramation 3 [ry, cramatory or			Feb 24			
rten		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Sarvice Lice	/	Maryla			Cemetery				
Deper mpor any fr		21. Signature di Fulliarai Salvice Lice	£ /,				ess of Fecility				
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		23a. Part1/Enter the diseasa, or con shock, or heart fail 9. List only	nplidations that caused ona causa on aach li	tha daath. Do i	not entar the mo	oda of dyir	ng, such as cardiac	or raspiratory a	rrast,	- 1	Approximata ntarval Between
nysician											Onset end Death
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physician and s the burial-transit	Examiner	Sequentially list conditions,		Dua to (or as a	consequence of)):					
cian		Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Ceuse (Disaasa or Injury that initiated events and the sequence of the control of the co								İ	
the	dic	that initiated events resulting in death) Last):								
ding b	Physician/Medical	L L	d								
ettendir for use	lan										
the e	/sic	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributions.							ontributa to t	he cause of death?	
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ies been signed by the ettending physician and a 2 should be detached for use es the buriel-transit	etec							24a. Wes	an autopsy ormed?	avaii	able prior to
hes b	Completed									of de	eath?
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ls certificate he director, page	Be	25. Was casa rafarred to medical axaminar?					26. Placa of Deat	th (Check only	ona)		
this co	L _o	1 A Yas 2 No	Hospital: 1 Inpatia		itpatient 3 D	OA Ott	har: 4 ☐ Nursing Ho	oma 5 🖾 Rasi	danca 6 □Oti	har (Specify)	
- O		27. Manner of Death 1 Netural 5 ☐ Panding	28a. Date of Inju (Month, Day	y <i>Year)</i> 28b. 1	Tima of njury	28c. inju	ry at rk?	28d. Describe	how injury occu	med	
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ithin omple	M	29b. Signature and title of certifier	and maintai ste	1	29	9c. Licens	se number		29d Data signa	ed (Month, Di	av Year)
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		Francis Mayle,	M.D. 102	15 Ferny	wood Rd,	, #30)1 Beth	esda,Ma	ryland	20817	
Sta		31. Data filad (Month, Day, Year) FEB 20 199	32 Registra	ar's Signatura	2.00						
Registr	ar	100	1700	- ALACONA-N	ALINE DE						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey Yeer February 10, 1998 **Physician** William Henry Coleman, Jr. 12:40 PM /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□ F 012-12-5241 80 Yrs. Director Massachusetts Aug. 8, 1917 Usual Residence of Decedent 10e. Stete 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Potomac 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 238 7909 Sandalfoot Drive 20854 United States Funeral items 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☒ Married natural, or 1 ☐ Yes 2 ☒ No Specify: Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7 Department of Health end Mentel Hygiene. Important: if Item 27 is marked other then *n any filury or other treumatic event, tre Head pages. Elementery/Secondary (0-12) Collega (1-4or 5+) 5+ Automobile Dealer Automobile 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be William Henry Coleman, Sr. Evelyn Mayo 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Numbar or Rural Routa Number, City or Town, Stete, Zip Coda) Margaret F. Coleman/Wife 7909 Sandalfoot Drive, Potomac, Maryland 20854 20b. Placa of Disposition (Neme of cemetery, cremetery or other place Feb. 16, 1998 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cremetion 3 Removel from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Robert A. Fumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signeture of Funerel Service Licensee m M00198 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heaft feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medicai Immediate Ceuse (Finel disaase or condition resulting in death) e Cerebral Hemorrhage-Right Parietal Occipital Lobe 3 months Examiner Due to (or es e consequence of) Physician/Medical Examiner end I-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Undarlying Cause (Disease or injury Due to (or es e consequence of): physician er thet initieted evants resulting in daath) Lest Due to (or as e consequence of): 88 ettanding p ed by the Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Unknown Cerebral Vascular Disease-Multiple Cerebral Infarcts à 80 should Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of death? Right fronto-parietal & occipital lobes page 2 has Type II Diabetes Mellitus 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Placa of Deeth (Check only ona) Hospitel: 1 ☑ Inpatient 2 ☐ EP/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 2 No this funerei 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28d. Dascribe how Injury occurred Certification: 28c. Injury et Work? Affer 1 Neturei 5 Pending Investigation daath. 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be datamined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral C completaly filled edicai 29a. Certifian 1 Certifying Phyelcian: To the best of my knowledga, daath occurred at tha tima, date and piece, and due to tha ceuse(s) and menner as stetad. (Check only one) 2 Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner steted. 29b. Sign and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D01948 February 10, 1998 30. Name and address of person who completed cau e of daeth (Item 23a) (Type, Print) Maine Fitzgerald, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland 31. Dore filed (Month, Day, Year) 32. Registrar's Signeture State Lis Veridon Randelle

Registrar

the Marylend

72 hours aftar

The law requiras that the daath certificate be executed

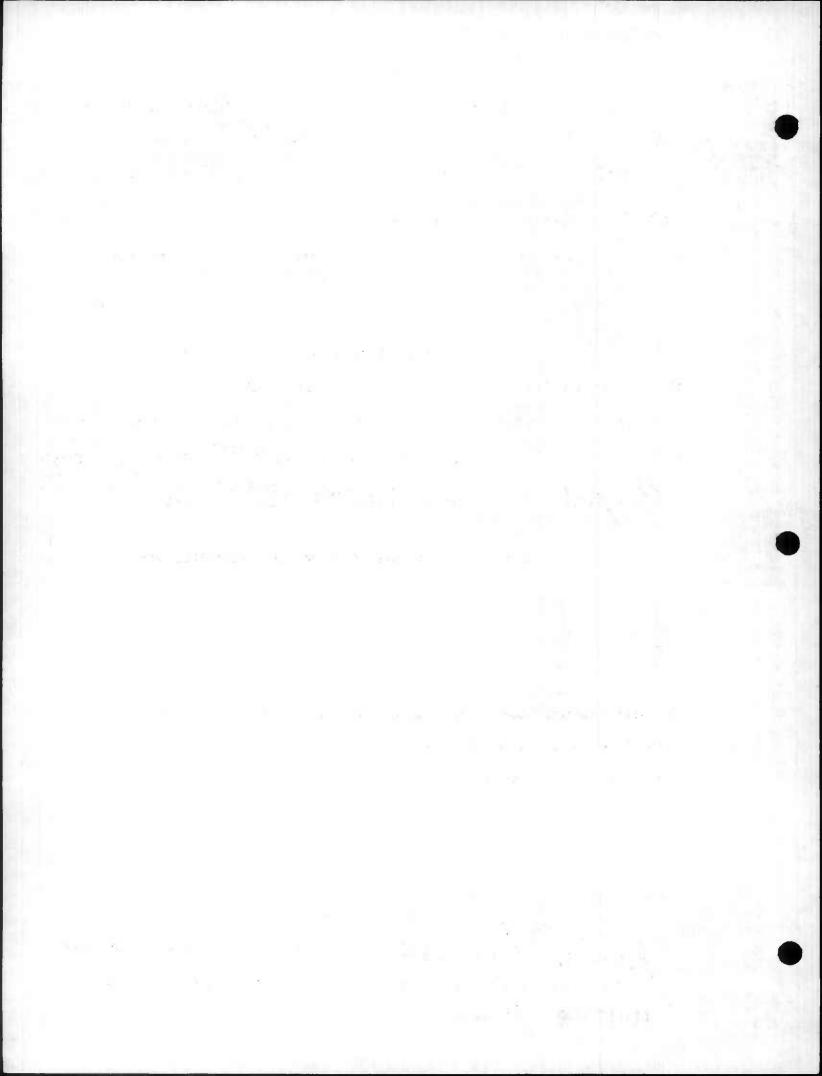
Box 68760,

P.O.

Records,

Division of Vital or Attending Physician:

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ARION 13 1998 FUBRUARY 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 26, 1914 5. Social Security Number 9. Birthplace (Stata or Foreign Country) New Jersey 7. Age (In yrs. last birthday) 1 □ M 28 F 83 213-38-2639 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring tx Yas 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 Whitmoor Terrace 20901 USA 12. Was Decedent Evar in U,S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 ☐ Navar Married 2 ☑ Married White 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Clark J. Wilkerson Ethel Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Cooper - Husband 209 Whitmoor Terrace Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Mount Comfort Crematory 2/18/98 Alexandria, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensi 22. Name and Address of Facility Joseph Gawler's Sons 5130 WI Ave. N.W. Washington, D. C. 20016 orications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disaase or condition resulting in death) structive Dua to (or as a consequence of): Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events rasulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Dtd tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

The law requires that the death cartificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. Stata

Directo

Funeral

ò

Completed

Be

MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedcal Examines must be notified at once.

Baltimore, Maryland 21215-0020

Examiner attanding physician and for usa as the bunal-transit Physician/Medical ģ Completed After this certificate has funaral director, page 2: Be Certification:

signed by the atte

1 ☐ Yes 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1₺ Inpatiant 2□ ER/Outpatient 3□ DOA

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28b, Tima of 28d. Describe how injury occurred 28c. Injury at Work?

28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending Investigation 1 Natural 2 Accidant 6 Could not be determined 3 Suicida

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and the of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) he

State Registrar

Medical

31. Date tiled (Month, Day, Year)

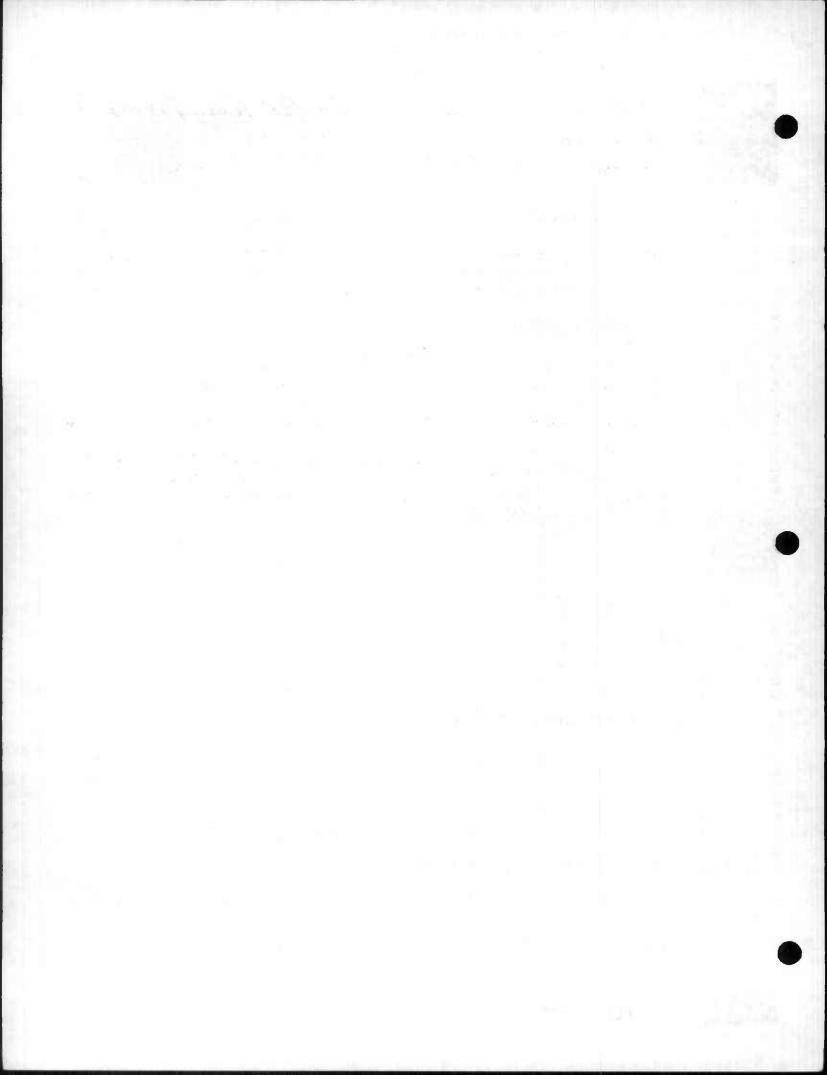
FEB17

32. Registrar's Signature Filia Davidson

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: within 24 hours aftar death. To the Funeral Director: Aftar this certifica

30



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month 13am 1891n19 Corbin -lorence 978 4a. Facility Neme (If not institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Death Hillhaven Nursing Home Adelphi, Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | July 1, 1906 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthpiece (State or Foreign 1□M 2XX Months 91 Yrs. 218-20-0600 Washington, D.C Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. tnside City Limits Maryland Prince George's Beltsville 1 Yas ANO 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4800 Wicomico Avenue 20705 United States 12. Wes Decedent Ever In U.S. Armed Forcas? 11. Meritai Status Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Biack, Whita, atc 1 ☐ Yas ŽŽQNo If Yes, Give Yaer or Datas: 1 Never Merried 2 Married 1 ☐ Yes XX No Specify: Specify: White Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Eiementary/Secondery (0-12) Coilege (1-4or 5+) Housewife own home 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Clifton Smith Botler Robertha Virginia Garner 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Marguerite Baggett (Daughter) same as #10 20e. Method of Disposition XXI Burial 2 Cremetion 3 Ramovei from Stete 20b. Plece of Disposition (Neme of cematary, crematory or other piece) Dete 20c. Location - City or Town, Stata Ft. Lincoln Cemetery 2/13/1998 Brentwood, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Fecility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 MUNOUT cations that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23e. Pert1. Entar tha disaase, or com shock, or heart feilure. List only Immedieta Causa (Finel diseese or condition resulting in death) PNEUMONIA 2 WEEKS Dua to (or es a consequence of): Sequentielly list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in deeth) Lest Dua to (or es e consequence of): Due to (or es a consequança of): 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of causa of daath? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

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funeral director,

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Medical

After this

or Attending Parties after death.

To the Hospital owithin 24 hours a To the Funeral D

certificate be executed

Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

Examiner

10a. Stete

Directo

Funeral

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Completed

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Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at

pernit. Peges 1 and 2 should be filled within 72 hours efter Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event. In Marked Exempted

Baltimore, Maryland 21215-0020

with the Meryland

death

Examiner Physician/Medical þ Completed Be 20 Certification:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA

25. Wes case referred to medical exeminer? 1 ☐ Yas ANNO

28. Piace of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) 28d. Dascribe how injury occurred

27. Mannar of Deeth 5 Pending investigation 1. Neture! 2 Accident 8 Could not be determined 3 Suicida

28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 1 Yes 2 No 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29e. Cartifiar (Check only one)

4 Homicide

12 Certifying Physician: To tha best of my knowledge, daeth occurred et tha tima, dete end pieca, end due to tha cause(s) end manner es steted.
2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred et the tima, dete and piece, and due to the ceuse(s) and mannar stated.

29b. Signeture and title of cartifia

29c. License number D 31563

29d. Data signed (Month, Day, Year) FEBRUAR: 11, 1998

30. Neme end eddrass of person who completed cause of death (Item 23a) (Type, Print)

CHARLES M BENNER 31. Dete filed (Month, Day, Year)

FEB17

11251 WIKWOOD DRIVE, SILVERSPRING 20901

State Registrar 32. Registrer's Signetura

and the second of the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended #3,2/26/98 per MD State of Maryland / Department of Health and Mental Hygiene 9 Amended #2, 2/26/98, per MD, JW, Mont. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Beath . m. **Physician** Edna T. Claflin February 8, 1998 4:50pm /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Suburban Hospital Bethesda Montgomery 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
Jan. 22, 1902

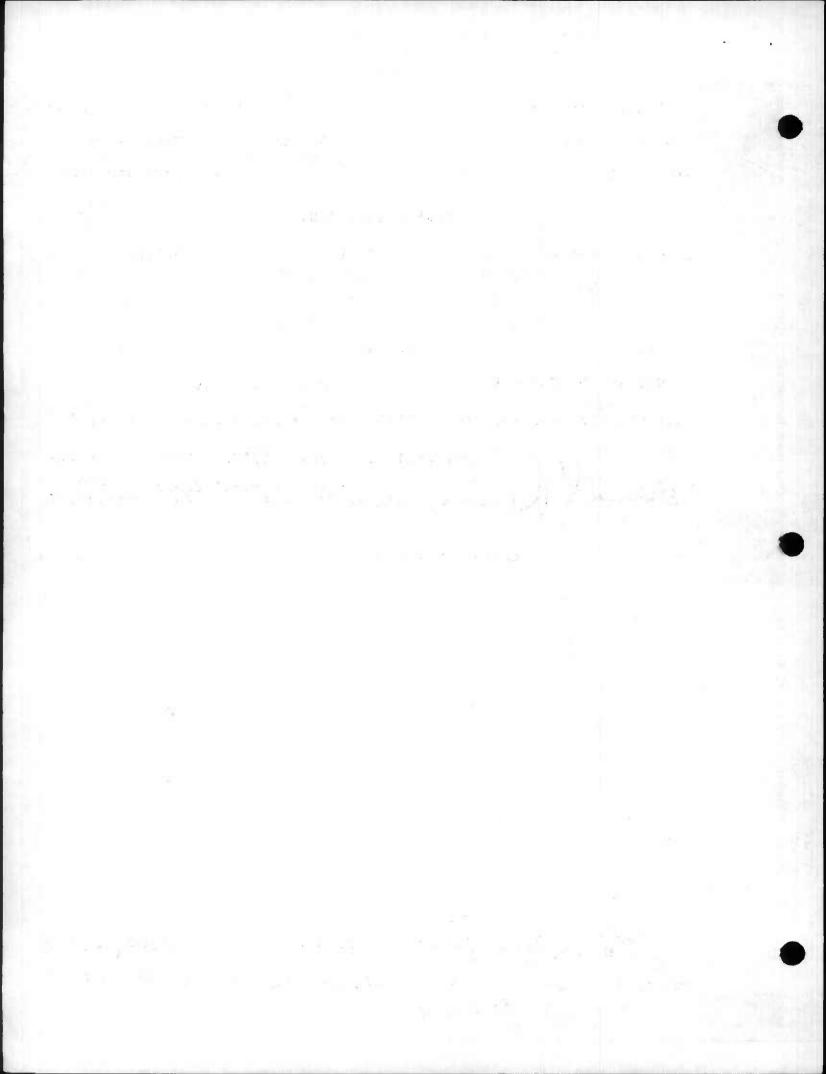
9. Birthplece (Stete or Foreign Maryland 6 Sex 7. Age (In vrs. lest birthday) **Funeral** 10 M X0 F Months Days Hours Min 96 Yrs. Director 577-12-1168 Usual Residence of Decedent 10e Stete 10b County 10c. City. Town or Location 10d. inside City Limits 28a-f show with the Maryla the Medical Examiner must be notified at N/A N/A 1 XYes 2 No Director Washington, D.C. 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 23a or 3050 Military Rd. N.W. 20015 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Raca - American Indien, Black, White, etc. thems. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiens. 1 Never Married 2 Married 8 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced 'hatural' Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Department of Health and Mental Important: If Item 27 is marked or any Injury or other traumatic eve Wilbert W. Torbert Clara V. Sitzs 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Gail Claflin/Daughter-in-law 4710 Bethesda Ave.Bethesda, MD 20814 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removal from State lational Mem. Park 2/10/98 Falls Church, VA 4 □ Donation 5 □ Other (#ipe hty) 22. Name end Address of Fecility 21. Signature of Funeral Servi Ives-Pearson Funeral Homes 472 N. Washington St. Fall N. Washington St. Falls Church, Pert1. Enterthe disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician mediete Ceuse (Finel disease or condition /Medical Diverticu litis I week Examiner resulting in deeth) The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest pue Due to (or es e consequence of): अ (१ (१ %) Records, P.O. Box 68760, physicien Physician/Medical ed by the attending physical deteched for use as the Due to (or es e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? After this certificate has been signed by tonneral director, page 2 should be detect 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evaileble prior to completion of cause of death? filled in by the funeral director, page 2 should Completed 24a. Wes en eutopsy 1 Yes 2 NO 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No efter death 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 D Homicide ò To the Hospital o within 24 hours ef To the Funeral Di completely filled in Medicai Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and 29c. License number 29d. Dete signed (Month, Dey, Year) of certifier D41205 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 11119 ROCKVILLE PIKE #502, ROCKVILLE, MD SWARTZ MD Aeglatrar Signature State

DHMH 16 Rev 6/95

Registrar

AZAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06749 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of the th 2 Date of Death Month **Physician** 10 30 pm ADELA RETES CARLSTEIN 02 03 /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Suburban Hospital Bethesda if Under 24 Hrs. Montgomery If Under 1 Year 5. Sociei Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funerai** 10 M 20 F Months Deys Hours Min 214-08-6537 Director 90 Nov. 15 1907 Venezuela Usual Residence of Deceden the Merylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Bethesda 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? deeth with items 23a or 5301 Westbard Circle Apt.#240 20816 Venezuela 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours efter 1 Never Merried 2 Married 8 1⊠Yes 2□No Specify: Venezuelan by Specify: White 3 Widowed 4 □ Divorced "natural" Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) Collage (1-4or 5+) own home Housewife 12 Baltimore, Maryland 17, Fether's Neme (First, Middle, Lest) Be 18. Mother's Neme (First, Middla, Malden Surneme) . Peges 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 is marked oth jury or other treumatic even 2 Francisco de Paula Reyes Emma Ponte 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) permit. Peges 1 and 2 a Depertment of Health or Important: if item 27 is eny injury or other treu once. Emma C. Illarramendi / Daughter 5301 Westbard Circle #240 Bethesda, Maryland 20816 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Mathod of Disposition 20c. Locetion - City or Town, Stete 1 ☐ Burlei 2 ☐ Cremation 3 ☐ Removel from State Mother (Specify Entombment Gate of Heaven cemetery Feb. 10'98 Silver Spring, Md. 21. Signature of Fu neral Service Licenses 22. Name end Address of Facility DeVol Funeral Home a 2222 Wisconsin Ave., N.W. Washington, DC 20007 23e. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiretory errest, shock, or heart feitura. List only ona ceusa on each line. Approximete Intervel Batween Onset end Deeth Physician /Medicai Immediete Ceusa (Final Myocastial 1 much diseese or condition rasulting in deeth) Examiner Due to (or es e consequence of): chelmo usul 1 mute Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): 1 must Preumia Physician/Medical Due to (or es e consequence of): duy Hert railere amotre Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? igned by 1 Yes 2 No 3 Probably 4 Unknown Diulita melletis Hyrutholdin þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of daeth? Completed 24e. Wes en eutopsy performed? Limillation 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certific Be 25. Wes case referred to medical exeminer? 26. Pleca of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28c. injury et Work? 28b. Time of 28d. Dascribe how Injury occurred Certification: no 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident after death Director. 3 Sulcide 6 Could not be determined 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Cartifier 1 Certifying Physicien: To tha best of my knowledge, daath occurred et the tima, deta end place, and due to the ceuse(s) end menner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner stated.

State Registrar 31. Dete filed (Month, Day, Year) FEB 17 1998

29b. Signeture end title of certifier,

JUSE A. QUINOS MD 43 43 MONTCOMERT N BETHESUL MO WY14 32. Registrer's Signeture

30. Nema and addrass of person who complated cause of death (Itam 23a) (Type, Print)

29c. License number

DZ9256

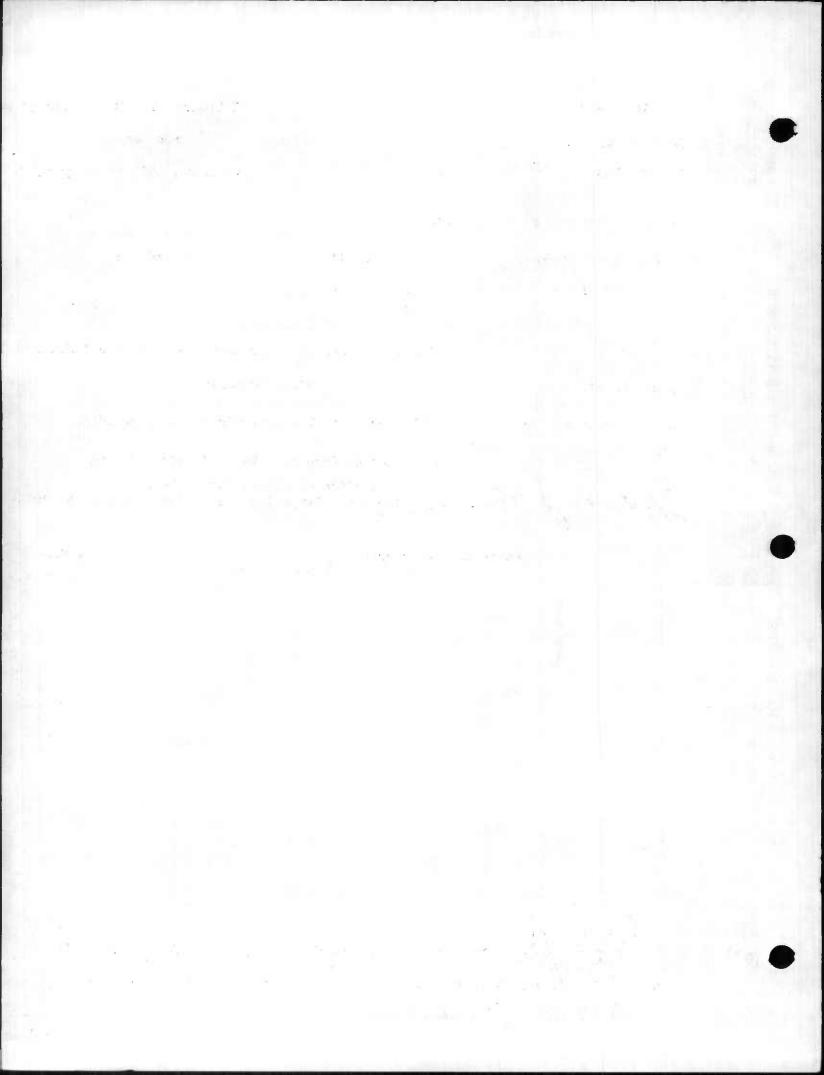
29d. Date signed (Month, Dey, Year) February 4, 1998

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State of Maryland / Department of Health and Mental Hygiene 8 06750

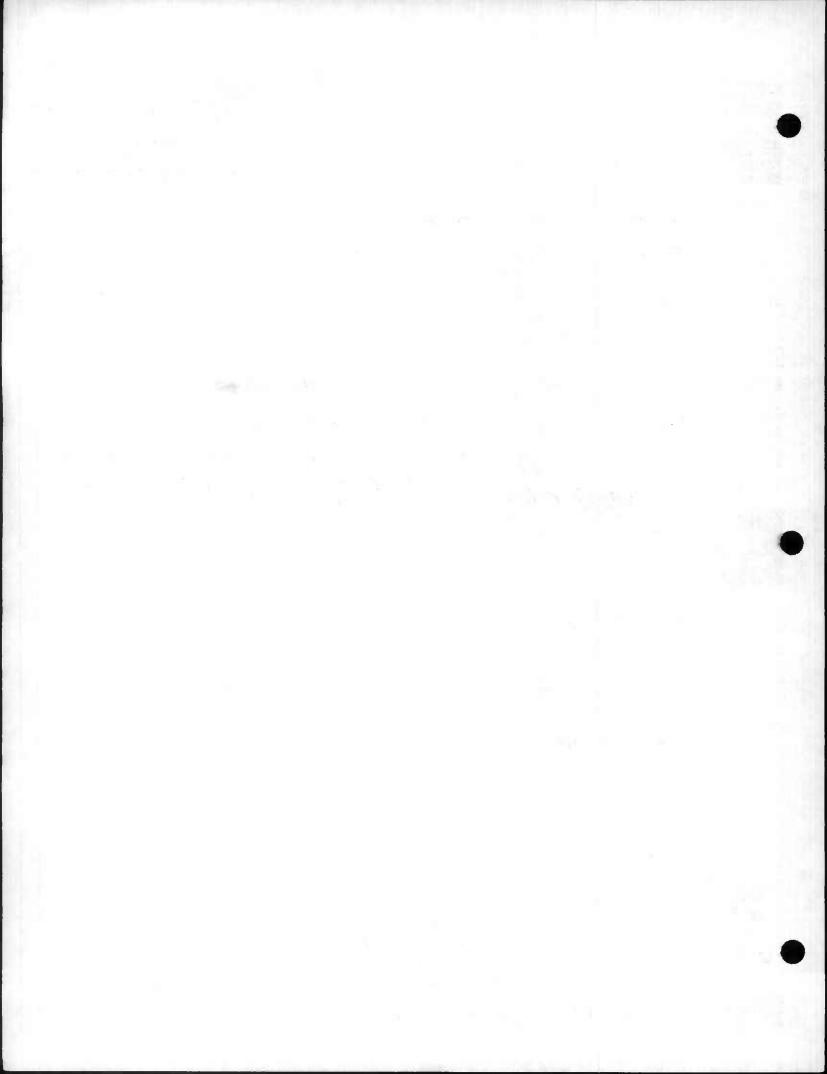
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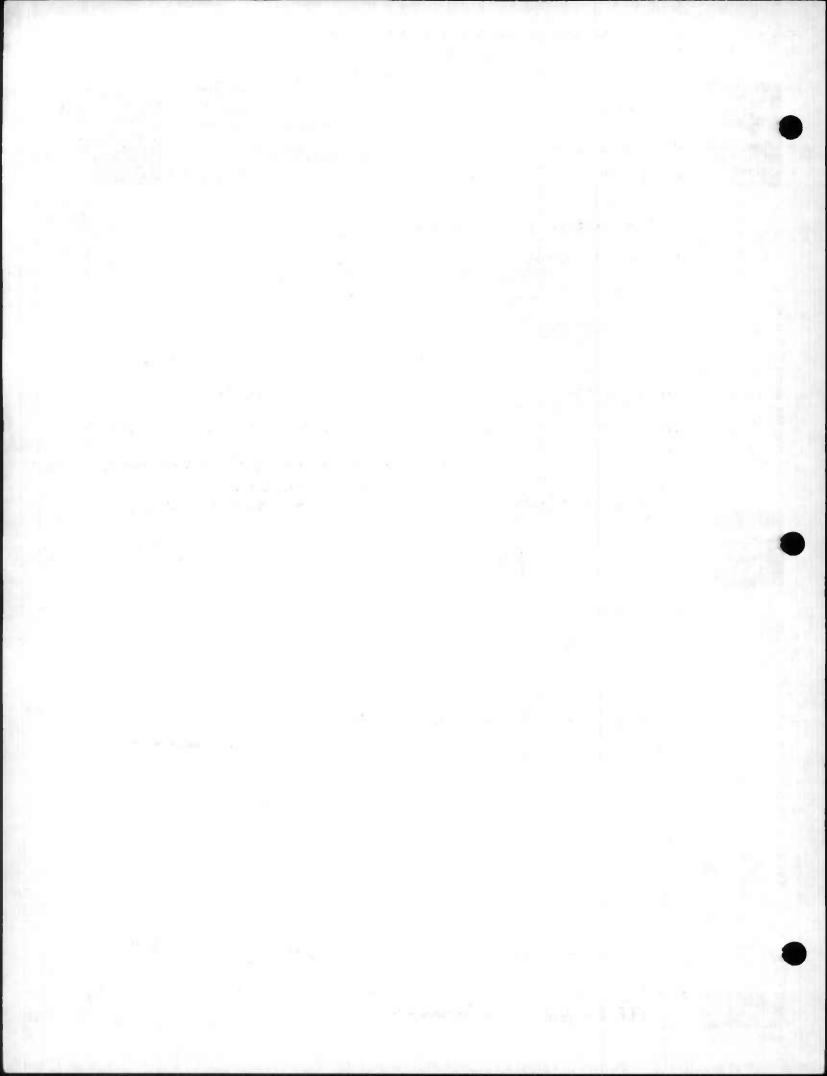


State of Maryland / Department of Health and Mental Hygiene 98 06751

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	ter death with the Marylan Items 23a or 28a-f show Iner must be notified at		109. Street end Number 10714 Potomac Tenr	nis Lane			10f. Zij 2085					10g. C U.S.		/het Coun	lry?	
Maryland 21215-0020	be filed within 72 hours efter death with the Maryland tiel Hyglene. Id other than "naturel", or flems 23a or 28e-f show event, if a Medical Examine, must be notified at	by Funeral	11. Maritai Status 1 □ Naver Marriad 2 □ Marriad 3 ☑ Widowad 4 □ Divorced	12. Was Decedant Ex Armed Forcas? 1 ☐ Yes 2 ②No If Yas, Giva Yaar or Datas:		if	f Yas, spe	cify Cub	Hispenic Orig an, Maxican Specify:	gin? (Sp , Puerto	ecify Yas or No Ricen, etc.)	-	Black	e - Amarica k, Whita, e Whit	etc.	
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			30. Nama and address of person who of Michael Grady, M.		Massac			ve.	N. W.	. 1	Washing	ton	, D.	С.	20016	5
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			State of Marylar		tificate of			Reg. No.) ()(0/52	
Physic /Med		Decedent's Nema (First, Middla, Last) Ming Sun Chen					2. Data of Do Month Feb 1		Yaar	3. Time of Death 19:15pm	
Exam Funera Director	iner I	4a. Facility Nama (If not institution, giva strict Holy Cross Hospita 5. Social Security Number 6. Sax 561-41-7259 Usual Rasidance of Decedant		last birthday) Yrs.	_	4b. City, Town, or 11 ver Sp 1f Undar 24 Hts Hours Min.	ring	Mont g	omerv	a (Stata or Foraign	
how Lat		10a. Steta 10b. County	10c. Ci	ty, Town or Lo	cation			10d. Insida City Li			
ith the Ma or 28a-f s	Directo	Maryland Montgomer 10e. Street and Number	y Roo	ckville	10f. Zip Coda			1 ☐ Yas 2 ☑ N 10g. Citizen of What Country?			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, in Morice Examinat must be notified as angles.	by Funeral	13215 Vandalia Driv 11. Maritai Status 1 Navar Marriad 2 Married 3 Widowed 4 Divorced	e Was Decedent Evar in U Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:	10	If Yas, specify Cuban, Max		spanic Origin? (Specify Yas or Non, Maxican, Puerto Ricen, atc.) Specify:		A Amarican - Whita, atc. Asian		
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33		30. Nama and address of parson who comp		n 23e) (Type, F	1700 Print) 700	Bucking	ham	Feb 18,1	ספנ		
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State of Maryland / Department of Health and Mental Hygiene

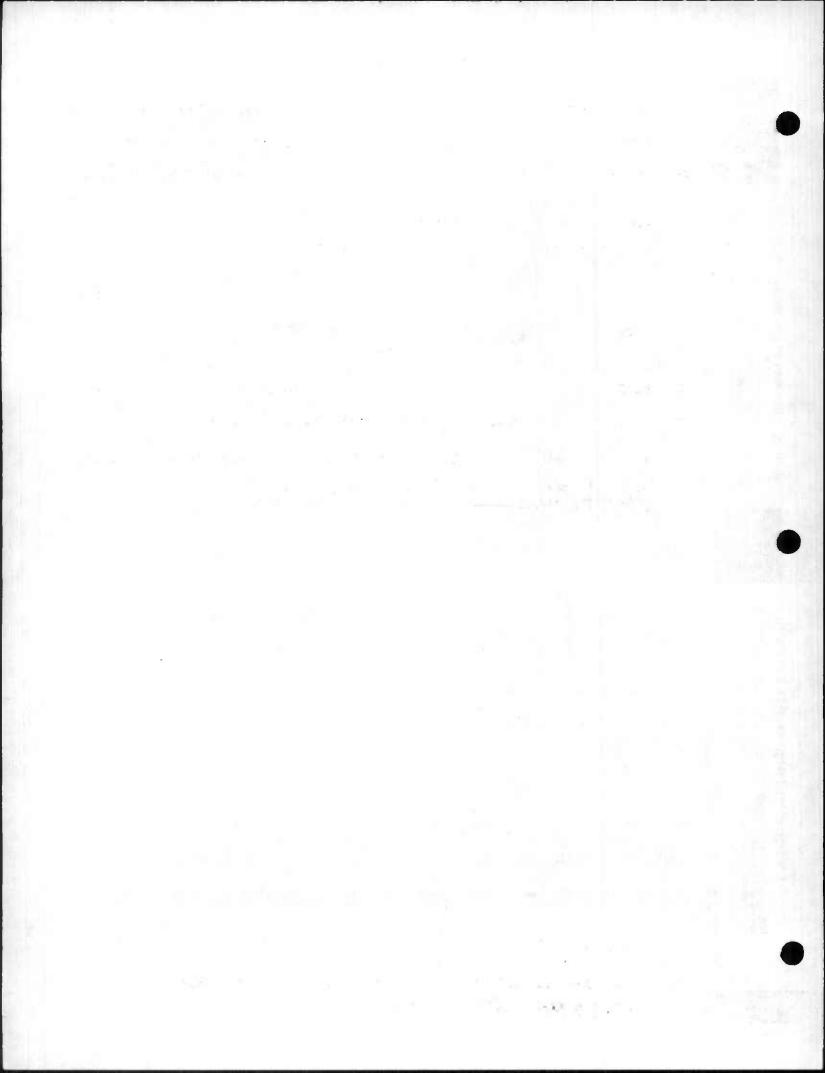
Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Data of Daath 3. Tima of Death **Physician** Month Leroy Merlin Christensen Feb. 1998 5:25 PM /Medical 4a. Facility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 4908 Somerset Road Riverdale Prince Georges 5. Social Security Number If Undar 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) June 14,1916 Birthplace (Steta or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days 1⊠M 2□ F 81 555-07-9900 Director Yrs. Iowa Usual Rasidance of Dacedant 10a State 10b. County 10c. City, Town or Location must be notified at 10d. Insida City Limits Director 1 Yas 2□No Prince Georges Riverdale 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Items 23a 4908 Somerset Road 20737 Funeral USA death 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispenic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. should be flied within 72 hours effer and Mental Hygiena.

merked other than "natural", or he 1 Naver Married 2 Merried 1 Yas 2 No If Yes, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grada completed) Elemantary/Secondary (0-12) Cottega (1-4or 5+) Truck Driver 12 Private permit. Pages 1 end 2 should be flie Department of Health end Mentai Hy Important: If flam 27 is merked othe any joinry or other traumatic event, sonce. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Surname) Christen Marinas Christensen Elvena Christina Christensen 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Thelma M. Christensen 4908 Somerset Road, Riverdale, MD 20737 / Wife 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a, Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) 2/18/98 Riverdale, MD Chambers Crematory 22. Nama and Address of Facility Chambers Funeral Homes, P.A. 21. Signatura Funaral Service License M1014 5801 Cleveland Ave., Riverdale, MD 20737 23a. Part 1. Entar tha disaasa, or complications that causad tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Batw **Physician** /Medical Immadiata Causa (Final CANCINOMA OF HYPOPHAR ANX 7 10005 diseasa or condition rasulting in daath) Examiner -transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last pue Dua to (or as a consequence of): physician e s the buriel-t Box 68760, Physician/Medicai Due to (or es e consequence of) P.O. Part tl. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Records, þ Completed 24a. Was an autopsy performed? Wara autopsy findings available prior to complation of causa of death? ata has 1 Yas 2 No this certificata 1 Yas 2 No Division of Vital Hospital or Attending Physician: 24 hours effar death. Funeral Director: Affer this certifica stelly filled in by the funeral director, p Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 28e. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 28f. Location (Streat and Number or Rurel Route Number, City or Town, Stata) 4 Homleida To the Hospital or within 24 hours eff To the Funeral DI completely filled in cai 29a. Cartifiar 1 🖫 Cartifying Phyalcian: To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Madicat Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner steted. 29b. Signatura end titla of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) D05891 2-16-78 (Ugn 30. Nama and addrass of parson who completed cause of death (Itam 23a) (Type, Print) Roger B. Ingham, 6510 Kenilworth Ave., Ste 2400, Riverdale, MD 20737 32. Registrer's Signetura State Registrar

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State of Maryland / Department of Health and Mental Hygiene

	H	1. Decedent's Name (First, Middle, La	est)		Certifica	01	Dodaii	2. Date of D		3. Time o	of Deeth
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xamin		4e. Fecility Name (If not institution, given	re street end number)				4b. City, Town, o	Location of Dea			
		2604 Ferguson Co					Waldo:			RLES	
nerai ector			Sex 7. Ag	e (In yrs. last bii 74	Yrs. If Unde Months	Days				9. Birthplece (Stete Country) Virginia	or Foreig
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MIDS	al Di	2604 Ferguson Co	urt			2060	2		US.		
edical Examiner must be notified at	by Funeral	11. Maritel Status Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y		13. Was Dece If Yes, spe 1 \(\superscript{Yes}\)		Hispenic Origin? (ean, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	o- 14. Raci Blac Specify	a - American Indien, kk, White, etc. White	
20	Completed	15. Decedent's E (Specify only highest gra Elementery/Secondery (0-12)	ducation ade com <i>pleted)</i> College (1-4or 5	16e	Decedent's Usu (Give kind of wo life. DO NOT u	al Occu rk done se retire	petion during most of wo ad)	orking	16b. Kind of Bu	care	
vent, ti	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Ne	eme (First, Middle	a, Meiden Sumem		
netic ev	ToB	Lee H. Carter							ght Cart		
r traur		19e. Informant's Name/Relationship (Robert L. Black					St. Wald		ber, City or Town, 20603	Stete, Zip Code)	
or oth		20a. Method of Disposition 1 ☐ Burial ② Cremation 3 ☐			f Disposition (Nerry, cremetory or o			Date		City or Town, Stete	941
any injury or once.		4 Domation 5 Other (Specifical Signature of Fuheral Service Licer		Metrop			atory 2-	24-98	Alexand	ria, VA	
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cian		23a. Pagy Enter the disease, or com	plications thet caused one cause on each lin	the death. Do	not enter the mod	le of dyi	ng, such es cardia	ac or respiratory	errest,	Approxime Interval Bel Onset end	tween
dical liner		Immediate Cause (Finel disease or condition resulting In death)	θ	Caron	any Ar	ton	1 Disens	e			
ă.	iner				consequence of):					Yers	
as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events	D	Due to (or es e	consequence of):	1,0	orth			Years	>
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	on: To	1	1 ∐ Inpatier 28a. Date of Injur (Month, Dey	y 28b. 1		8c. Inju Wo	4 LI Nursing	1	how Injury occurr		
completely filled in by the funera	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		ry - At home, fa	М		Yes 2 □ No	28f. Location (City or To	(Street and Number wn, State)	er or Rurel Route Num	n <i>ber,</i>
eletely fille	edical C	29a. Certifier (Check only one) Certifying Ph. 2 Medical Example	yeiclan: To the best of liner: On the basis of and menner ste	f my knowledge examination end led.	, deeth occurred d/or Investigation	at the ti	me, date end plec opinion, death occ	a, and due to the urred et the time,	cause(s) end me dete end place, e	nner es steted. and due to the cause(s	s)
сош		29b. Signature and title of certifier	1	1	290	1 - 11 - 1	se number		29d. Date signed	(Month, Dey, Yeer)	
		Modern 1	Jun		M	0	40479		2123	155	
		30. Name and eddress of person who		- 11		Je - A	Mada a	. M. 20	602		
		Robert Davison M 31. Dete filed (Month, Dey, Yeer)		d Line r's Signature		vest	waldori	, MD 20	OUZ		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Nama (First, Middle, Last) 2. Deta of Death **Physician** FEBRUARY 20 MARIE LOUISE CHAPPARS 1998 10:20 AM /Medical 4a. Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner 21611 Meadow Wood Lane Prince George's Brandywine If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Numbar 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, May 25 Birthpiaca (Stata or Foreign Country) 1□M 2X F 88 Yrs 219-36-7628 Indiána Usual Rasidanca of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Prince George's Director Brandywine 1 Yas 2 No 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? 21611 Meadow Wood Lane 20613 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Dacedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indlen, Black, Whita, etc. 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Nevar Merried 2 Married 1 ☐ Yes 2 No Specify: White þ Widowad 4 □ Divorced Specify Be Completed 15. Decedant's Education (Spacify only highast grade complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Public School School Teacher 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Charles Glass Elenore Rabe Glass 19a. Informant's Name/Ralationship (Type, Pnnt) 19b. Mailing Addrass (Straet end Numbar or Rural Routa Number, City or Town, Stata, Zip Code) Mary E. Landon-Whitlow (Daughter) 21611 Meadow Wood Lane Brandywine, MD 20613 20a. Method of Disposition 20b. Placa of Disposition (Nama of camatery, cramatory or other pleca) 20c. Location - City or Town, Stata 1 ☐ Burial 2 XCramation 3 ☐ Ramoval from State 5 Othar (Specify) Metropolitan Crematory 2-21-98 Alexandria, VA 21. Signatury of Fundral Sarvica Licensee 22. Nama and Address of Fecility J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695 M00173 Entar the disaasa, or complications that causad the death. Do not enter the moda of dying, such as cardiac or respiretory errast, or haart failura. List only ona causa on aach lina. Approximata Intarvai Batw Onset and Death immadiata Cause (Final CARDIA- ARREST disaesa or condition rasulting in death) MINUTES Dua to (or es a consaquanca of): Physician/Medical Examiner ATHEROSCHEROTIC NEDRT PISCASE 20 4 EARS Saquantially list conditions, if any, laading to Immadiate causa. Entar Underlying Causa (Diseasa or injury thet initiated avants rasulting in daath) Last Dua to (or as a consequence of) Dua to (or es e consequanca of): Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION à 24b. Wera autopsy findings aveileble prior to complation of causa of daath? Completed 24a. Was an eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical Be 26. Placa of Death (Check only ona) Hospital: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) Certification: To 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Yas 2 No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of injury - At homa, farm, streat, fectory, office building, atc. (Specify) 4 Homicide 12 Certifying Physician: To tha best of my knowladge, death occurred at tha tima, data and piece, end dua to tha causa(s) and mennar as steted.
2 Medical Examiner: On tha basis of examination end/or invastigetion, in my opinion, death occurred et tha tima, date and piece, end due to tha causa(s) end mannar stated. 29a. Certifier Medicai 29b. Signatura end titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) x 35640 2/20/91 30. Nama and address of person who completed causa of daath (item 23e) (Type, Print) Sarah Leonhard, MD, JD 13605 Baden Westwood Rd Brandywine, MD 20613

32. Registrar's Signatura

State Registrar 31. Dete filed (Month, Day, Year)

FEB 2 3 1998

Funeral

Director

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Items 23s

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Physician /Medical

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page 2 certificate

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After

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To the Hospital within 24 hours e

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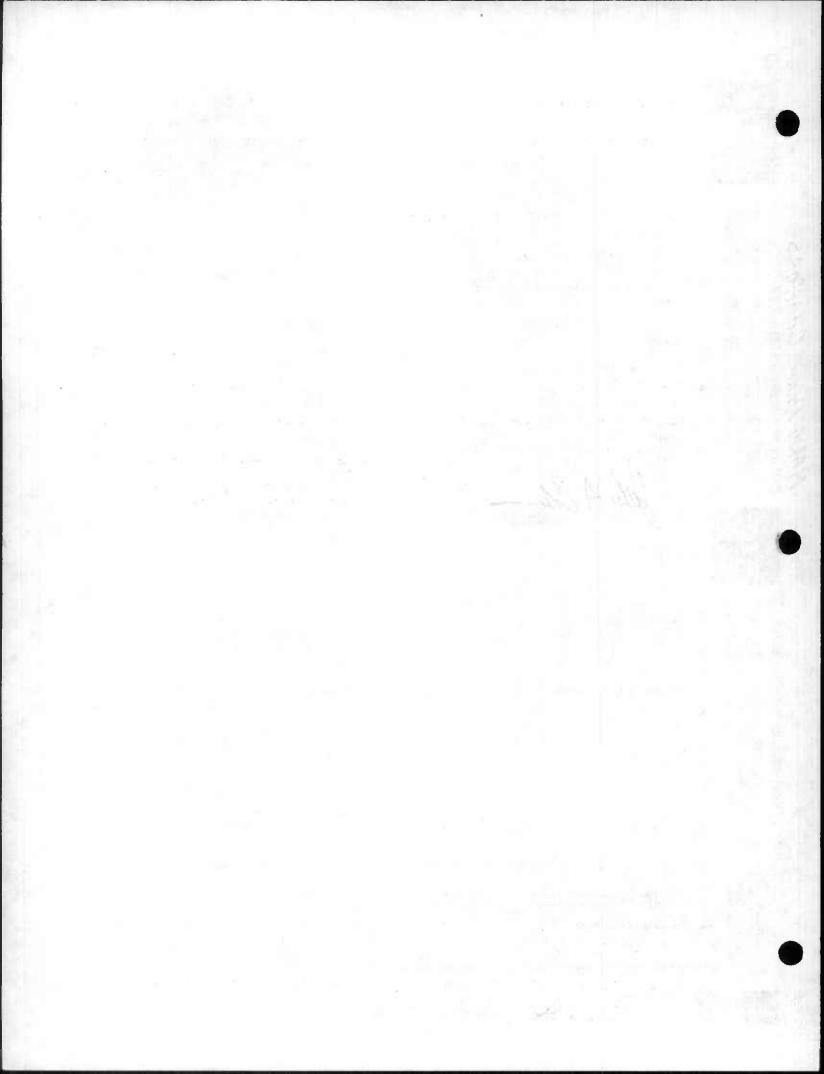
P.O. Box 68760,

Records,

Division of Vital

Pages 1 and 2 should be nert of Health and Mental

MRIE LOUISE CHAPF



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Mary Ann Cummins February 14, 1998 5:04 P.M. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital Oakland Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Birthpiace (State or Foreign Country) 1 M 2 X F Yrs Director 231-66-8451 80 July 17, 1917 Delaware Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Med cal Examiner mant be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Garrett Friendsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2001 Friendsville Road 21531 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, atc. 11 Marital Stafus 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) 3 years Homemaker Peges 1 and 2 should be filed vinent of Health and Mental Hygie int: If Item 27 Is marked other I Own Home 17. Fathar's Nama (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Herbert Gibbons Rebecca Shivery 19a. Informanf's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 a Department of Health ar Important: If Item 27 Is any Injury or other trau Robert S. Cummins/husband 2001 Friendsville Rd., Friendsville, MD 20b. Placa of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Country Side Crem. Feb. 15, 98 Davidsville, PA 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility Newman Funeral Homes, P.A., P.O. Box 275 in, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) a Pneumonia Examiner 1 week Due to (or as a consequence of): Examiner Parkinson's Disease 15 years The law requires that the deeth certificate be executed attending physician and I for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or Injury that Initiated avents resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Pert II. Other signiffcant conditions contributing to death buf not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. the 23b. Did tobacco use contribute to the cause of death? 2 should be detec 1 Yes 2 No 3 Probably 4 Unknown by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? has 1 Yes 2 No After this certificate or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1. Inpatient 2 ER/Outpatienf 3 DOA 28c. Injury af Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation Natural 1 ☐ Yas 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28a. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide To the Hospital of within 24 hours a To the Funerel D edicai Certifying Phyalcian: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifiar 29c. Licensa number 30. Neme and ad of person who completed cause of death (Item 23a) (Type, Print) Johnson 743 , M.D., 311 N. 4th St., Oakland, MD 21550

DHMH 16 Rev 6/95

State

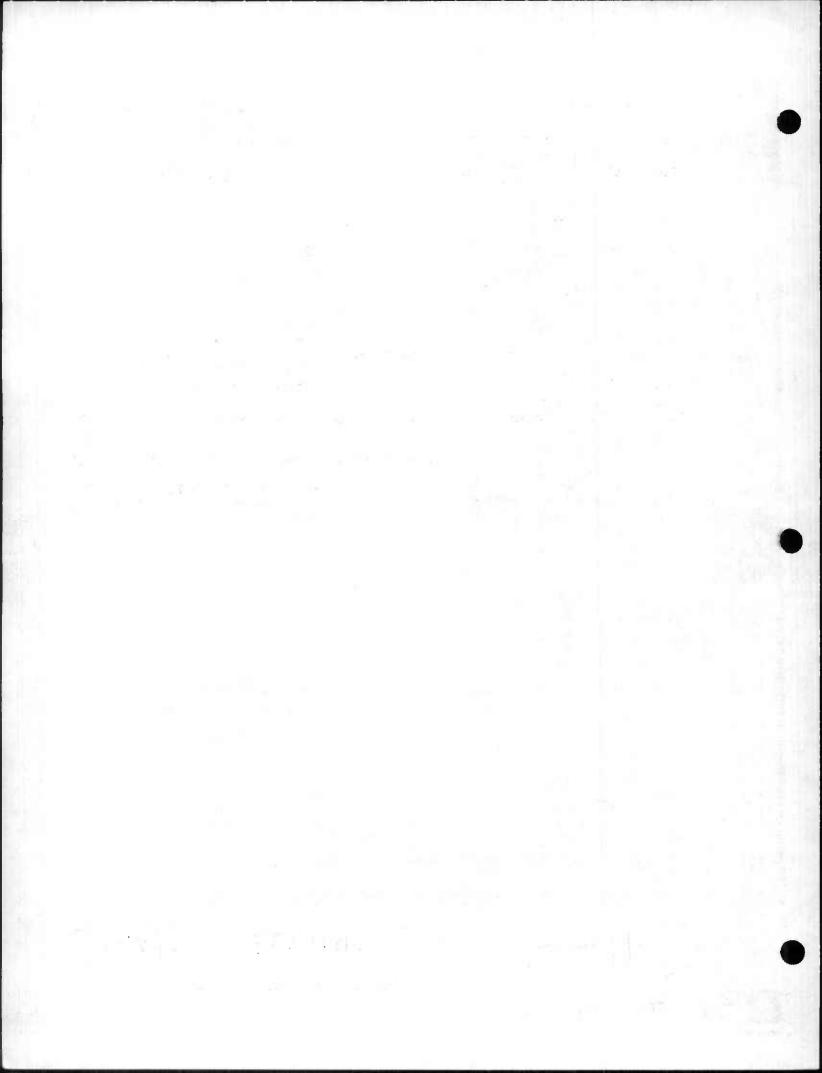
Registrar

31. Date filed (Month, Day, Year)

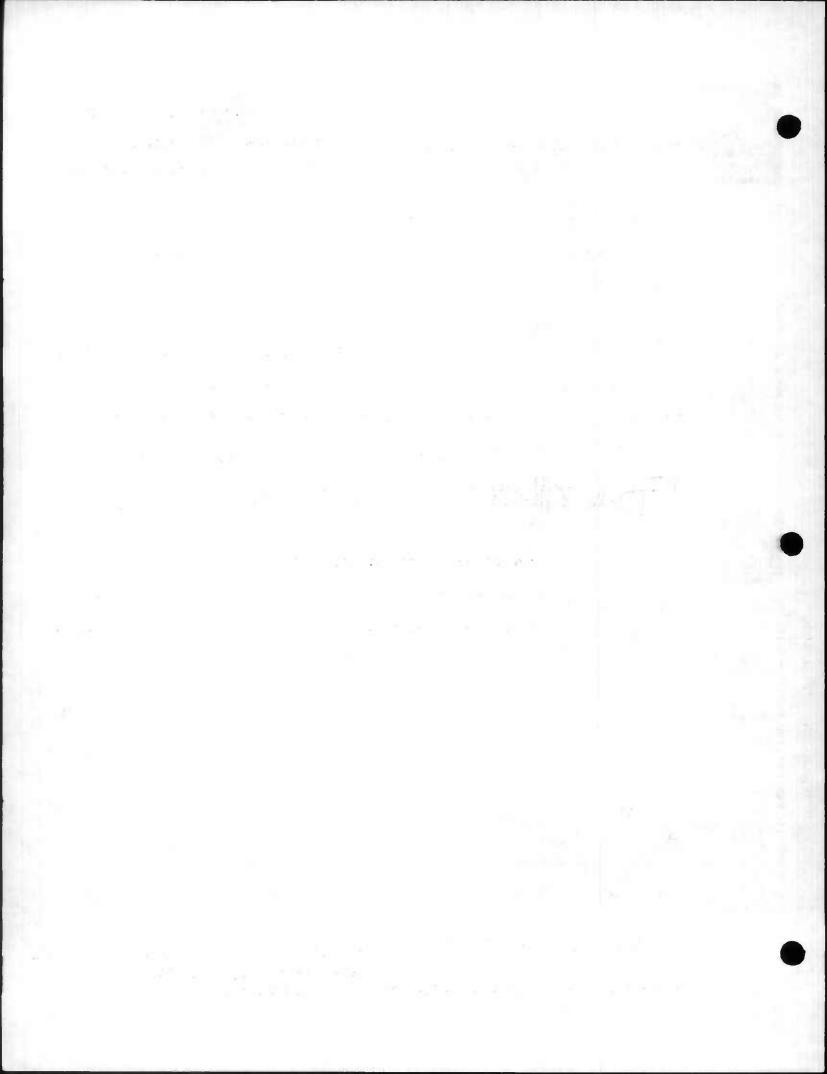
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32, Registrer's Signature



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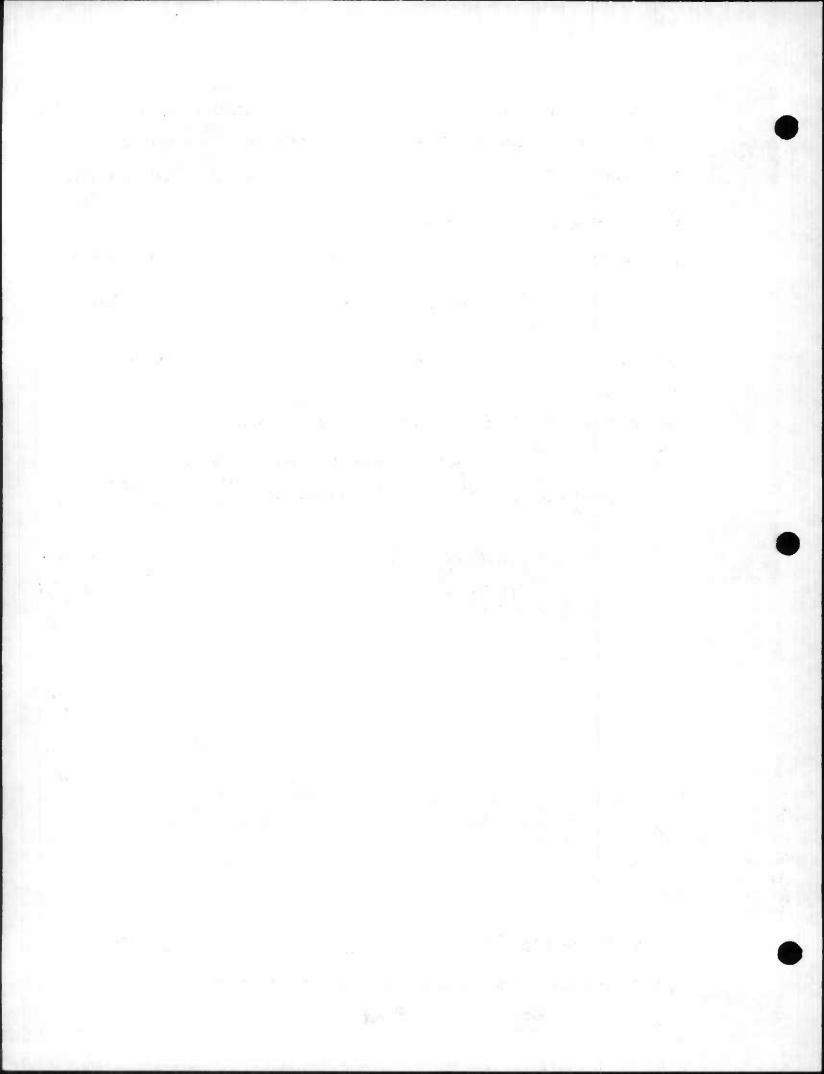
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month FEBRUARY 15 1998 William Clay 12:30 AM /Medical 4e. Fecility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** 1**j** M 2□ F Days Hours Yrs Director 68 234-38-7829 March 26,1929 West Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 No Director WV Mineral Piedmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 238 51 Jones Street 26750 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Status 72 hours after 1 1 Yes 2 No If Yes, Give Year or Dates: 1951-52 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No þ Specify: Black 3 ☐ Widowed ♣☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 th end Mental Hygiene. 7 is marked other than "ne Elementery/Secondary (0-12) College (1-4or 5+) Laborer B & O Railroad Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Willie Clay Laura Price 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Health en Important: If Item 27 is any injury or other trau Moniek France / Daughter 3rd Street Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens 2/18/98 Keyser, WV 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 111 Church Street 20 ny Boal Funeral Home Westernport, MD 21562 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final endrage COPD disease or condition resulting In deeth) Examiner Examiner bunel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest pue Due to (or as e consequence of) physician e Box 68760. Hospital or Attending Physicisn: The law requires thet the deeth certificate be to a hours efter death.

Funeral Director: After this certificate has been signed by the ettending physicial. Physician/Medical Due to (or as a consequence of) esn Ö signed by the e Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. LUTHER CLAY 234-38-7829 P.O. Division of Vital Records, P.O. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24a. Was en eutopsy performed? Completed 24b. Were autopsy findings evailable prior to completion of cause of deeth? cate hes t 2 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manper of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours e 29a. Certifier 1🗹 Certifying Phyelcien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted. Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 98 20 D44712 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 21502 NANNETTE MCCULLOUGH M.D., P.O. BOX 3188, LAVALE, MD 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Michaelan Jack Registrar



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State of Maryland / Department of Health and Mental Hygiene	9	8	1	6	7	61	
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						C	ertifica	ate of	Death	F	leg. No.) (10/0	U
Physic	ian	1. Decedent's Name (First, M	iddla, Li	ast)	1. 3					2. Date of Dea Month	th Day	Year	3. Time o	of Death
/Medi		Pearle Eve	-							Feb 17		Tour	6:08	am
Exami	ner	4a. Facility Name (If not institu							4b. City, Town, or	Location of Death	4c. County	of Death	1	
	ш	Dennett Rd.	-						Oakland		Garr	ett		
Funeral Director		5. Social Security Number 215 36 9860		Sex 7.7 1□M 2√2 F	Age (In yrs. 89	last birthda Yrs.	Month	ler 1 Year s Days		8. Date of Birth (Month, Day Apr 8		9. Birth Cou Md	nplace (State untry)	or Foreig
yland		Usual Residence of Decedent	nty			y, Town or	Location						10d. tnside (City Limits
Sa-f st offilied	Director		rett		SWe	anton							1 ∑ Yes	2 □ No
death with the Maryland ms 23s or 28s-f show r.must be notified at	ral Dira	10e. Street and Number 3502						21561		1	USA	What Co.	intry?	
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Hygi Hygi and the		17. Father's Name (First, Midd	fle, Last)					18. Mother's Nar	ne (First, Middle, i	Maiden Suman	ne)		
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MAS 2 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	_	19a. tnformant's Name/Relati William Kisn	onship (Type, Print)					and Number or Ru Kitzmil		, City or Town, 21538	State, Zi	ip Code)	
permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1√2 Burlat 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other			e	tace of Disemetery, co	ematory of	other pla		Date eb 19'98	20c. Location -			
444		21. Signature of Pinerat Serv		**	De				ess of Facility	ED 17 70	Deel	Lain	TIC	
permit Departimonta any Inju		1//		A ,	h				Burdock	FH				
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		23a. Part . Enter the disease shock, or heart failure. I	or com	one cause on each	ed the deatl tine.	n. Do not e	nter the m	ode of dyi	ng, such as cardiad	or respiratory arr	est,	İ	Approxime Interval Be	tween
Physician /Medical Examiner		Immediate Cause (Final disease or condition		a Acut	e Con	gesti	ve He	art :	Failure				Onset and	
Examile		resulting in deeth)				ras a cons							- 0	
ted nsit	F			b. Chro	nic H							1	10 ye	ars
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2 s b	Completed									24a. Was a perform	n autopsy ned?	an Co	Vere autopsy vallable prior ompletion of death?	to
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ng Physician: ther this certific uneral director,	2	1 Yes 2 No 27. Manner of Deeth Netural 5 Pen	ding	Hospital: 1 ☐ tnpat 28a. Dete of tn (Month, D		ER/Outpati 28b. Time tnjury		28c. tnju	v at // Nursing H	lome 5 Reside			fy)	
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lal or Attending P is after death. In Director: After the ed in by the funera	Certification:		mined	286. Placa of Ir	njury - At ho etc. <i>(Specif</i>)	me, farm, s	treet, facto	ry, office		28f. Location (St City or Town		er or Run	a / Route Nun	n <i>ber</i> ,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certification (Check only one) 1 Medic	ying Ph at Exan	ysicien: To the besi niner: On the basis and manners	of examinet	vledge, dee ion and/or l	nvestigetio	d at the tir n, in my d	me, dete and placa plnlon, death occu	, and due to the corred at the time, d	ause(s) and ma ate and place,	inner as s and due t	steted. to the cause(s	s)
To the within 2 To the comple	Me	29b. Signature and title of cert	fier	/	/ .		25	c. Licens	e number	2	9d. Date signe	d (Month,	Day, Year)	
->-0		Marga	rex	aka	uxi	4/	D	D2	26650		2/17/9	8		
		30. Name and address of person					Oakl	and h	(D) 21550					
		Margaret A. K 31. Date filed (Month, Day, Yan	aise		Box 4		Uakt	anu l	טכנוג עו					
Sta Registr	_	sate med (merin, pay, ra	/	oz. negisi	nai s oignai	9	B 44	The same						



State Registrar od couse of daoth (Itam 23a) (Type, Print)

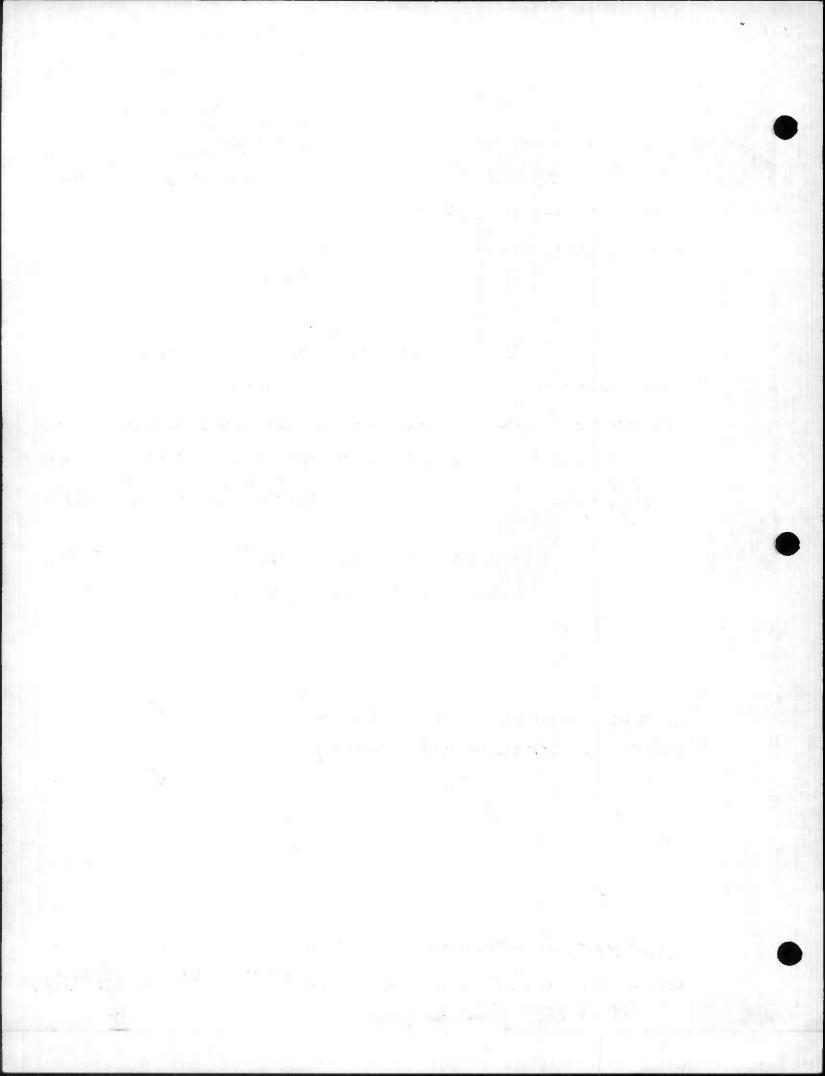
Tohns Hopkins Hospital, 600 North Wolfe Street, Balhimore,
Maryland 21287

32. Registrer's Signature

30. Nema and addrass of person who complated ceuse of daeth (Itam 23a) (Type, Print)

Wolfenden

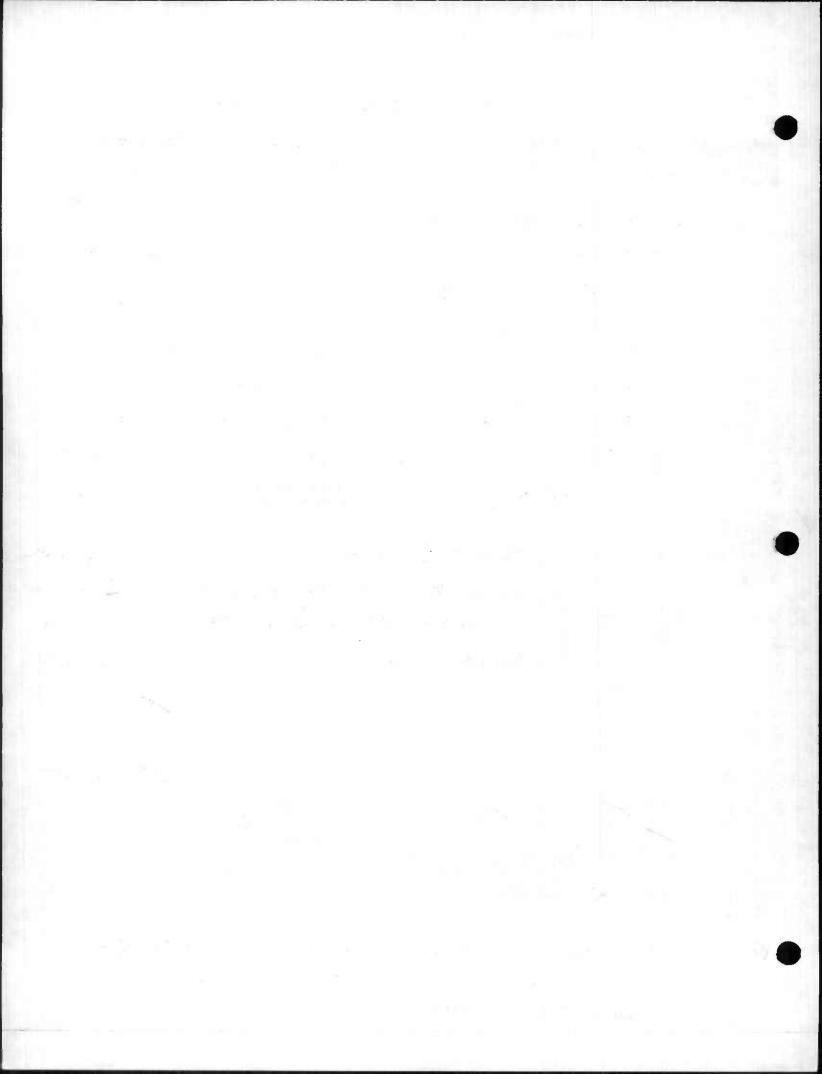
31. Dete filed (Month, Dey, Year) FEB 20



State of Maryland / Department of Health and Mental Hygiene

				Certificate of	f Death	F	Reg. No.	00/02
	1. Decedent's Name (First, Mid	die, Last)		1000		2. Date of Dea	ath	3. Time of Death
sician		Howard	Richard	Davis		Februar	ry 17, 1	998 8:40 AM
edical miner	4a. Facility Neme (If not Instituti	on, give street and number	or)		4b. City, Town, or		, ,	
iiiiiei	Anne Arundel I				Annapoli	c		Arundel
	5. Social Security Number		Age (In yrs. lest birthe	day) If Under 1 Yea				
ral	156-20-4069	1 X M 2□F	68 Yr	Months Day			V Year	9. Birthplace (State or Forei
Ų.	Usuel Residence of Decedent		00			Teb. Za	, 1323	Pennsylvania
	10a. State 10b. Count	у	10c. City, Town of	or Location				10d. Inside City Limit
5	Manuland Anno	Arundel	Crofton	n				1 ☐ Yes 2 N
Directo	Maryland Anne	Arunder	CIOICO					
à				10f. Zip Code			10g. Citizen of V	
2	1596 Eton Way			21114			United	States
Funeral	11. Marital Status	12. Was Deceder Armed Forca	nt Ever in U,S.	 Was Decedent of if Yes, specify Cu 	Hispenic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		a - American Indien, ck. White, etc.
	1 ☐ Never Married XX Ma	If Yes Give	™01951-	1□ Yes 2\1 N			Specifi	
1 by	3 Widowed 4 Divorce	d Year or Datas	1953	12 100 4210	о орошу.		Specify	White
Completed	15. Decade	nt's Education est grade completed)	16a. D	ecedent's Usual Occ	upation	rking	16b. Kind of Bu	usinass/Industry
pid	Elementary/Secondary (0-12)	Collega (1-4o	'/ı	ife. DO NOT use reti	ed)	King		
0	12	4		esman / Ov	ner		Brick	
Be	17. Father's Name (First, Middle	, Last)			18. Mother's Na	me (First, Middle,	Maiden Sumen	18)
ToB	Richard Davis				Elizal	oeth Kar	oolski	
-	19a. Informant's Name/Relation	ship (Type, Print)	19b. N	Mailing Address (Stre	et end Number or R			State Zin Code)
	Scott R. Davi	s (so	\	8 Patrice		Crofton		1114
	20a. Method of Disposition	, , ,	, 103	isposition (Name of	CITCIE,	Date		City or Town, State
	1 Burial 2 Cremetion	3 Removal from State	e cemetery,	cremetory or other p				
	4 Donation 5 Other (Specify)		ake Crema				lle, Maryland
	21. Signature of Funeral Service	Licansee		Rapp Fune	ress of Facility	cos P	Λ	
	Cleen	N. Kan	200					MD 20910
	23a. Part1. Enter the diseese, of	or complications thet caus	ed the death. Do no	933 Gist				Approximate
	shock, or haart failure. Lis	t only one cause on each	line.					intarval Between Onset and Death
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Sici	Part II. Other significant condit	ons contributing to death	but not resulting in ti	ne underlying cause of	given in Part I.	23b. Did t	obacco use co	ntribute to the cause of deat
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Completed						1 🗆 Y	es 2 No	1 ☐ Yes 2☐ No
Be	25. Was case referred to medic examiner?	al			26. Place of De	ath (Check only o	ne)	
2	1 Yes 2 No	Hospital:	tient 2 ER/Outp	etient 3 DOA	thar: 4 Nursing F	Home 5 Rasid	lence 6 Oth	ar (Specify)
	27. Menner of Death	28a. Date of In			ury at	28d. Describe h	ow injury occur	red
Certification:	Natural 5 ☐ Pand 2 ☐ Accident inves	igation (MOTITI, L	Ney Year) Inju		Yes 2 No			
Ę	3 ☐ Suicide 6 ☐ Could	not be nined 28e. Placa of I	njury - At home, farm	, streat, factory, offic	9			er or Rural Route Number,
e	4 Homicide	building,	etc. (Specify)			City or Tow	n, Stete)	
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edicai	(Check only 2 Medica	Examinar: On the basis	of examination and/o	or investigation, in my	opinion, deeth occu	urred at the time,	date and placa,	and dua to tha causa(s)
Mec		end manner :	stated.	200 Lieu	nee eumber		20d Data siene	d (Manth Day Year)
	29b. Signature and title of certifi	ar	0	29C. Lice	nse number		zeu. Date signe	d (Month, Dey, Year)
	Hon co	222.96	mD	WO	4646	50	2/17	198
	30. Name and addrass of person	who completed cause of	deeth (item 23a) (Ty	/pe, Print)			1	1 WD SILL
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State	31. Date filed (Month, Day, Year		trace Signature		211 A.C.		Jaco !	4
trar	FEB 19	1998 Julia	Deviden Por	delle			•	
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12, 1998 February William Linwood Donaldson 8:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 4815 Oxbow Road Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | Months Deys Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1₩ 2□F Yrs. 69 Director 577-32-5549 July 14, 1928 Washington, DC Usuei Residence of Decedent deeth with the Marylend 10a State 10h County 10c. City, Town or Location 10d. fnside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 4815 Oxbow Road 20852 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 1945 If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours efter to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, it a Medical Examination. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: White 3 Widowed 4 Divorced Year or Detes: -1949 Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Nuclear Regulatory Records 12 Analyst Commission 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Linwood Emmett Donaldson 2 Mabel Estelle Schultz 19a. fnforment's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley D. Donaldson/Wife 4815 Oxbow Road, Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 15, 1998 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300. West Montgomery Avenue
Rockville, Maryland 20850-2805

completelon that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest,
Approximate Silver Spring, Maryland Signature of Funeral Se **Physician** Onset end Death /Medical Immediate Ceuse (Final Myocardial Infarction diseese or condition resulting in death) Immediate Examiner Due to (or es e consequence of) Examiner Coronary Artery Disease 5 Years The law requires that the deeth certificate be executed use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, nding physician Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Tyes 2⊠ No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? Respiratory Failure page 2 certificate 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1⊠ Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA After this c 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. within 24 hours after daath To the Funeral Director: A completaly filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital TM Certifying Physician: 1) the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

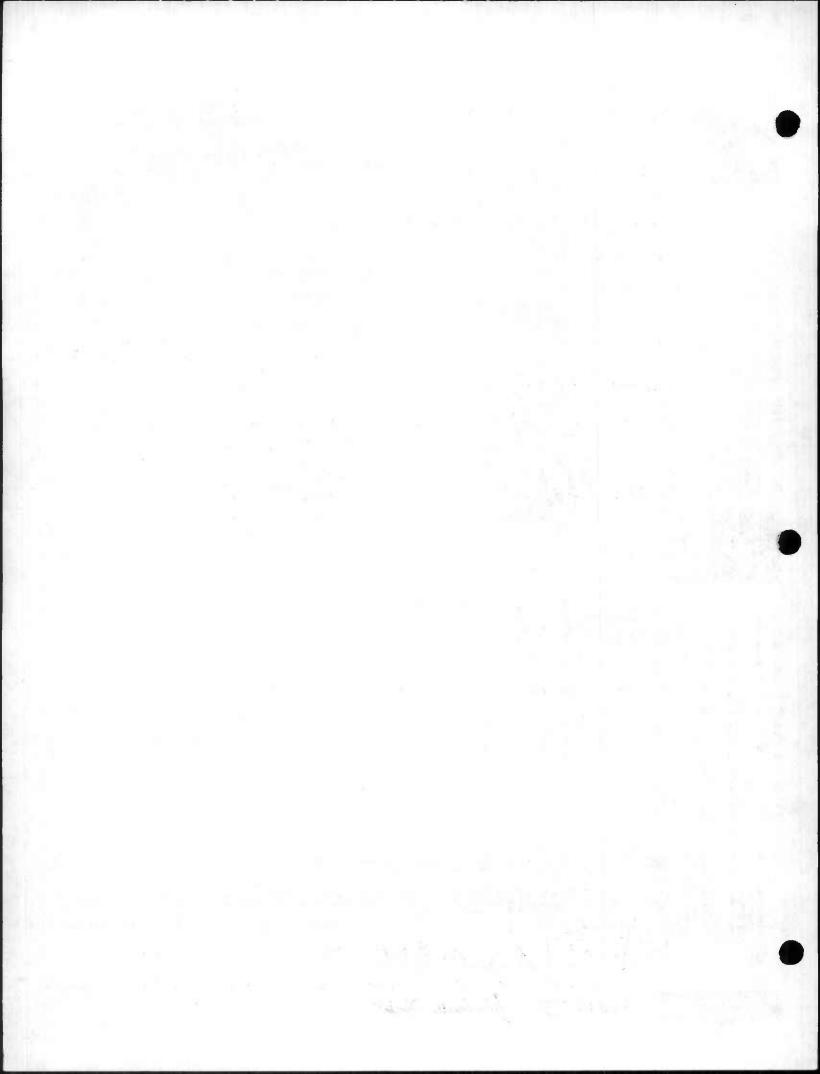
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 296. Signature and title of on 29c. License number 29d. Date signed (Month, Day, Year) D07471 February 13, 1998 30. Name and ad gess of person who d cause of death (Item 23e) (Type, Print)

50 West Edmonstone Drive, #207, Rockville, Maryland 20852

DHMH 16 Rev 6/95

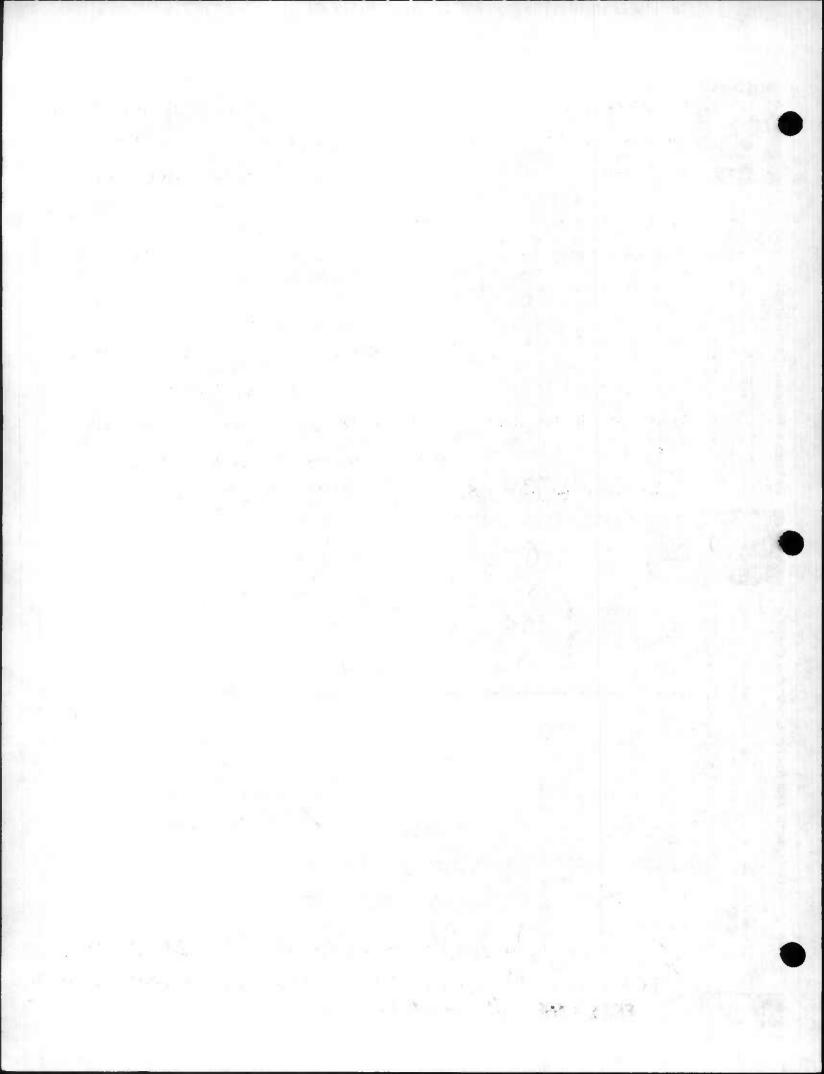
State Registrar Paul

T. Noone, M.D.



State of Maryland / Department of Health and Mental Hygiene 98 06764

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20 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, fectory, office 28e. Place of Injury - At home, farm, street, fectory, office 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 29a. Certifer (Check and Check	2 2	-	101108 20100	1 LI Inpatient			JA	ga Nu)	
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30 Name and address of person who completed causa of death (Item 23a) (Type, Print) AT TOTAL CO		-	100	1 4-12	11		()	NC	17	9	21	711	48	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Month 1811 Edward Dotson 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death General Dorchester Norchester Hospita ambroke 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 1XXM 20 F Days Hours 51 Yrs. 219-42-8994 May 24, 1946 Maryland Usuel Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes ZQNo Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4329 Cabin Creek Hurlock Road 21643 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ◯ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10th Fork Lift Driver Chesapeake Builders 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Ross Rosalie Dotson 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4329 Cabin Creek Hurlock Rd, Hurlock, Md. 21643 Rosalie Robinson, Mother 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/9/98 4 ☐ Donation 5 ☐ Other (Specify) Washington Cemetery Hurlock, Md. 21. Signature of Euperal Service Licensee 22. Name and Address of Fecility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, should be a cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth fmmediate Cause (Fine) Intracereh disease or condition resulting in death) Due to (or as a consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was an eutopsy performed?

Physician /Medical Examiner

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic svent, the Medical Examiner must be notified at

filed within 72 hours after Hygiene.

pernit. Pages 1 end 2 should be filed within 72 hours aftr Separtment of Health end Mental Hygiene. moortant. If item 27 is marked other than "natural", or i

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ettending physician for use es the burie been signed by the should be detached pege 2 director. Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

certificate

this

After

death.

To the Hospital or Attendir within 24 hours effer death.

To the Funeral Director: All completely filled in by the fu

P.O. Box 68760,

Records,

Division of Vital

Physician/Medical þ Completed Be 25. Was case referred to medical exeminer? 1 Yes Mapner of Deet

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Netural Accident

3 Suicide

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 ☐ Yes 2 ☐ No

28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

21613

28c. injury at Work? 28d. Describe how Injury occurred 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier

5 Pending Investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BYRN STREET CAMBRIT

an

31. Date filed (Month, Day, Year) State Registrar

edicai

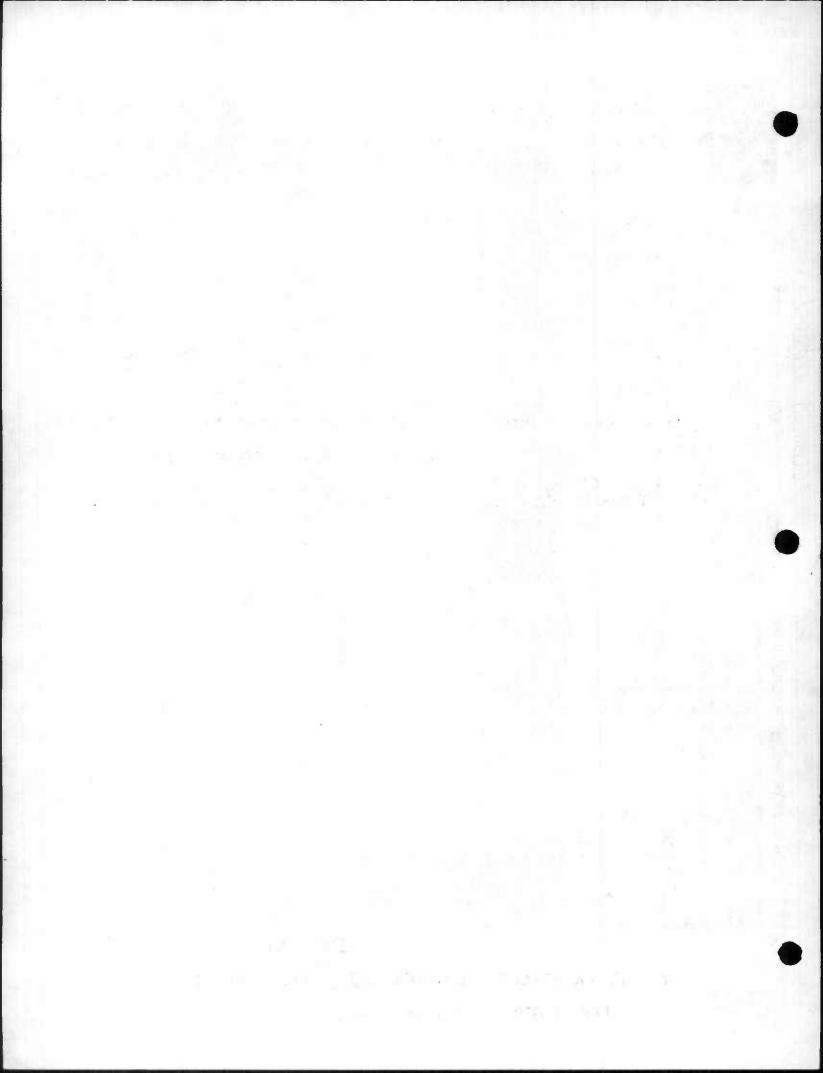
FEB 1 1 1998



1 Inpatient 2 □ ER/Outpetient 3 □ DOA

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Sur 10dd Dawson February 1998 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Cumberland Allegany Nursing Home umber land 4. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number Birthplece (State or Foreign Country) 1□ M 21 F 232-48-1696 March 28, 1901 Usual Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inside City Limits Alleg 1 ☐ Yes 2 No Director any land 10e. Street end Number 10g. Citizen of Whet Country? roms 6 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. 13. Wes Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritei Status 1 Never Married 2 Married 1 ☐ Yes 2 No by White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Education leacher 12 in CIPal 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Surneme) Margare Joseph 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number of Qurel Route Number, City or Town, Stete, Zip Code) Son oresi land 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Oak 98 Longconing 21. Signeture of Funerel Service Licenses 22. Name end Address of Facility Eichhorn - Mc Kenzie Funeral Home McKenzie ames 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. 21539 Longconing, Approximete intervel Between Onset end Death Immediete Ceuse (Finel disease or condition resulting in death) Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting In deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No Delizarchi 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

Physician /Medical Examiner iclan and burial-transit Hospital or Attending Physician: The law requires that the death certificate be axecuted

the

ate has been signed by the atter page 2 should be datached for u

After this certificate

filled in by the funeral

Medical Certification: To

Funeral

Director

28a-f show

6 items 23a

traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Heelih and Mantel Hygiene. Important: if Itam 27 is marked other than "neturel; or Item any Injury or other traumatic event. Its Mades Exempted.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

25.	Wes case	referred	to medical
	exeminer?		
	1 Yes	2 No	
_		7	

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

302

27. Menner of Deeth Neturel **E**□ Accident 3 Suicide 6 Could not be determined

28e. Dete of Injury (Month, Dev Year) 5 Pending investigation

28b. Time of 1 Yes 2 No

Other: 4 Surviving Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

unberland, old

29e. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifie

29c. License number

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

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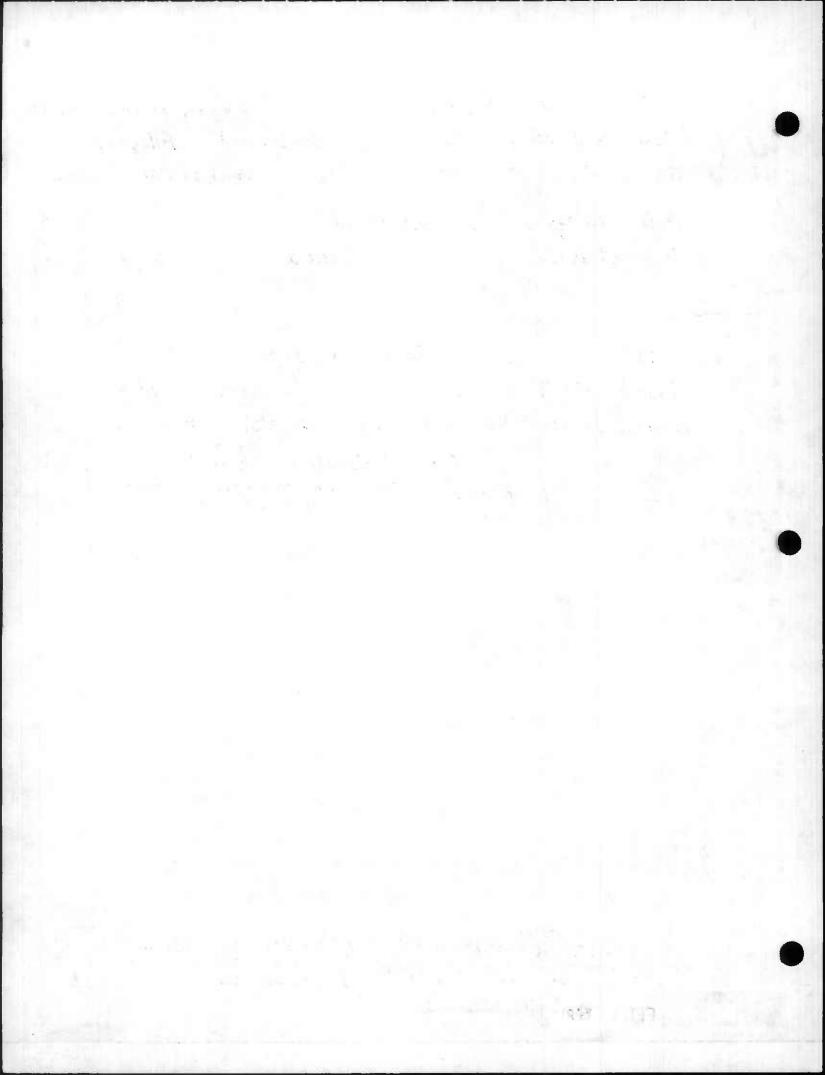
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To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al

31. Dete filed (Month, Dey, Yeer) State Registrar

32. Registrar's Signature, 8 1998

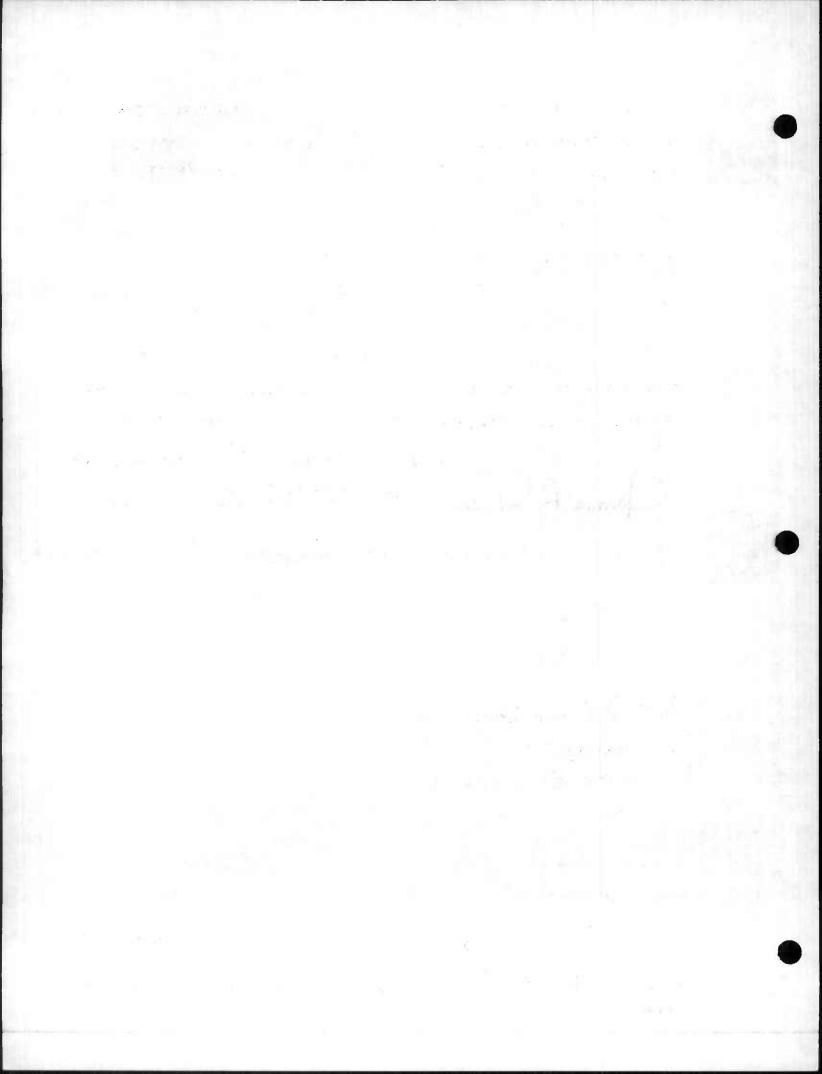
DHMH 16 Bey 6/95



State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day **Physician** Month Beulah May FEBRUARY 5 1998 9:15 AM /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Allegany Cumberland
If Under 24 Hrs. 8 Det 5. Social Security Number If Under 1 Year 8. Dete of Birth (Month, Day, Year) 11/15/1925 Birthplace (State or Foreign Country)
 Md 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF Days Hours 72 Yrs. Director 213-24-5244 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 XYes 2 No Director Morgan Paw Paw 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a P.O.Box 313 25434 USA Winchester St. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 natural', or Specify: White 1 ☐ Yes 2000 by 3₺ Widowed 4 Divorced Completed Ivent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 10 Steward Bar marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental It Pages 1 and 2 should be Claude Russell Crabtree Carrie Pauline Alderton 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If Item 27 is or other trau Patricia Saville (Daughter) P.O. Box 246 Paw Paw, WV 25434 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2/8 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removal from State Department o important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 98 Ginevan CEmetery Paw Paw, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McKee Funeral Home 23a Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or fleart failure. List only one cause on each line. P.O. Box 270 Augusta, WV Approximate Physician /Medical fmmediate Ceuse (Final disease or condition resulting in death) FCULAR 6 moonts Examiner Due to (or as e consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or as e consequence of): P.O. t II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown by Records, 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 this certificate 1 ☐ Yes ANO 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: T s after death. ii Director: After this certificat ed in by the funeral director, p 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direct completaly filled in b 4 ☐ HomicIde edical Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signeture end title of continue 29c. License number 29d. Dete signed (Month, Day, Year) February 5,1998 4 MACG 30 Name and eddress of person who completed cause of death (Item 23a) (Type, Print)
Robert Welik, H.D. 902 Seton Drive jumberland MD 21502 743 31. Date filed (Month, Day, Yeer) FEB 1 1 1998 32. Registrar's Signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene

		4 December 11 - 12 - 12 - 12 - 1	t - 4)		OUT	tificate of	Deam	-	Reg. No.		
Physic	ian	Decedent's Name (First, Middle,						2. Date of Month	Day	Yeer	3. Time of Death
/Medi		ELTA MAE EBE						FEBRU			11:15 AM
Exami	ner	4a. Facility Name (If not institution,						or Location of De	20 10 10 10 10 10 10 10 10 10 10 10 10 10		
		FROSTBURG VILLA 5. Social Security Number 6		G HOME	et hirthday)	if Under 1 Yea	FROSTBU			EGANY	(0)
Funeral Director		312-01-6643 Usuel Residence of Decedent	1 M 2 XF	80	Yrs.	Months Days		in. APRIL	Dey, Year) 15 1917	Ountr INDIA	ace (State or Foreig X) NA
how		10a. State 10b. County		10c. City,	Town or Loc	cation				10	d. Inside City Limit
Sa-fa	Director	MARYLAND ALLEG	SANY	CU	MBERL	AND					1 2 Yes 2 □ No
De ne	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Countr	ry?
a 23s	rai	826 MOUNT ROYAL				215				5.A.	
"natural", or items 23a or 28a-1 show	by Funeral	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 □ Yes 2 ☑ If Yes, Give Yeer or Dates:	? [No		Vas Decedent of Yes, specify Cul	Hispenic Orlgin? ban, Mexican, Pu Specify:	(Specify Yes or learn Rican, etc.)		ce - America ck, White, et y: WHIT	tc.
natur	Completed	15. Decedent's (Specify only highest of	Education		16a. Decede	ent's Usual Occu	pation during most of v	vorkina	16b. Kind of B	usiness/Indu	ustry
. E S	mpiqu	Elementery/Secondary (0-12)	College (1-4or	5+)	life. D	O NOT use retire	WELRY ST		SALES/F	RETATI.	
		12+ 17. Father's Name (First, Middle, La	4		J. I. DI	TIDE OF	-				
e do	Be C	DR. JOHN SCHULTZ							dle, Maiden Suman	ne)	
PEE	2	19e. Informant's Name/Relationship			19h Mailing	Address (Stree	FRIEDA		nber, City or Town,	State Zin (Code)
Heelth ar em 27 is ther trau		ROBERT LITTLE ER		SBAND					LAND MARY		
		20a. Method of Disposition			ce of Dispos	ition (Name of atory or other pla	nce)	Date	20c. Location	- City or Tow	m, State
ry or		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donetion 5 ☐ Other (Spec		Э			*	24 1998	CUMBERLA	ND MA	DVIAND
important: If it any injury or one		21. Signature of Funeral Service Lin	engl .	COMBE	22.	Name end Addr	ess of Facility			IND TIA	KILAND
any in		Tools of	Mount				DAMS FUN		ME RLAND MAF		
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ng physician and es the burial-fransit	Medical Examiner	disease or condition	a, b c	Due to (or a Due to (or es	Shei's Se consequ	muys ience of):	6:5	ense		3.50	Onset and Deeth Everel flavs
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death #12,2/23/98,BMW,Montg.CO Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Yaar **Physician** Eleanor D February 13, 1998 22:10 PM Eutemark /Medical 4a Facility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney If Under 24 Hrs. Montgomery If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Year) **Funeral** Deys Months Hours 1□ M 2₩ F Director 076-03-7562 June 13,1912 | Maryland Usuel Residence of Deceden the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Directo Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 14517 E1mhan Court, Mutual 10

11. Maritel Stetus

12. Was Decedent Ever in U,S. Armed Forces?

1 Married

12. Was Decedent Ver in U,S. Armed Forces?

1 Was Give 1943-4 with Funeral 20906 deeth S.A. 14. Race - American Indien, Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. filed within 72 hours efter 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1943-46 Specify. by 3 Widowed 4 □ Divorced White Completed 16e. Dacedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) . Pages 1 and 2 should be filment of Health and Mental Hant: If Item 27 Is marked offiury or other traumatic even Be Michael Robertson Stone Bessie Louise Gough 19a. Informant's Name/Reletionship (Type, Phint Daughter) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 9612 Scorpio Court 22015 Margaret L. Eutemark Smith Burke, Virginia 20b. Place of Disposition (Name of cemetery, crematory or othar place) 20e. Method of Disposition 2/27/98 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State permit. Page Depertment of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Name end Address of Fecility 21. Signeture J Funerel Service Licensee Francis J. Collins Funeral Home, Inc. Scunc 500 University Blvd., W., Silver Spring, MD 20901 Clon 23a. Pert I. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such es cardiec or respiretory errest shock, or heert failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel · CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner physician and the buriel-transit that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted avents resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): attending pt P.O. signed by the a Pert It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Nos 2 No 3 Probably 4 Unknown CONGESTIVE HEART Records. à 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica director Be 25. Wes case referred to medical 26. Place of Death (Check only one) exeminer? Hospitel: 1 Pinpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 4 - Homicide

3 filled in completely within 2 20

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

choenbage 16 220 31. Date filed (Month, Dey, Year)
FEB 20 19 32 Registrer's Signeture

ne end eddress of person who completed cause of death (Item 23e) (Type, Print)

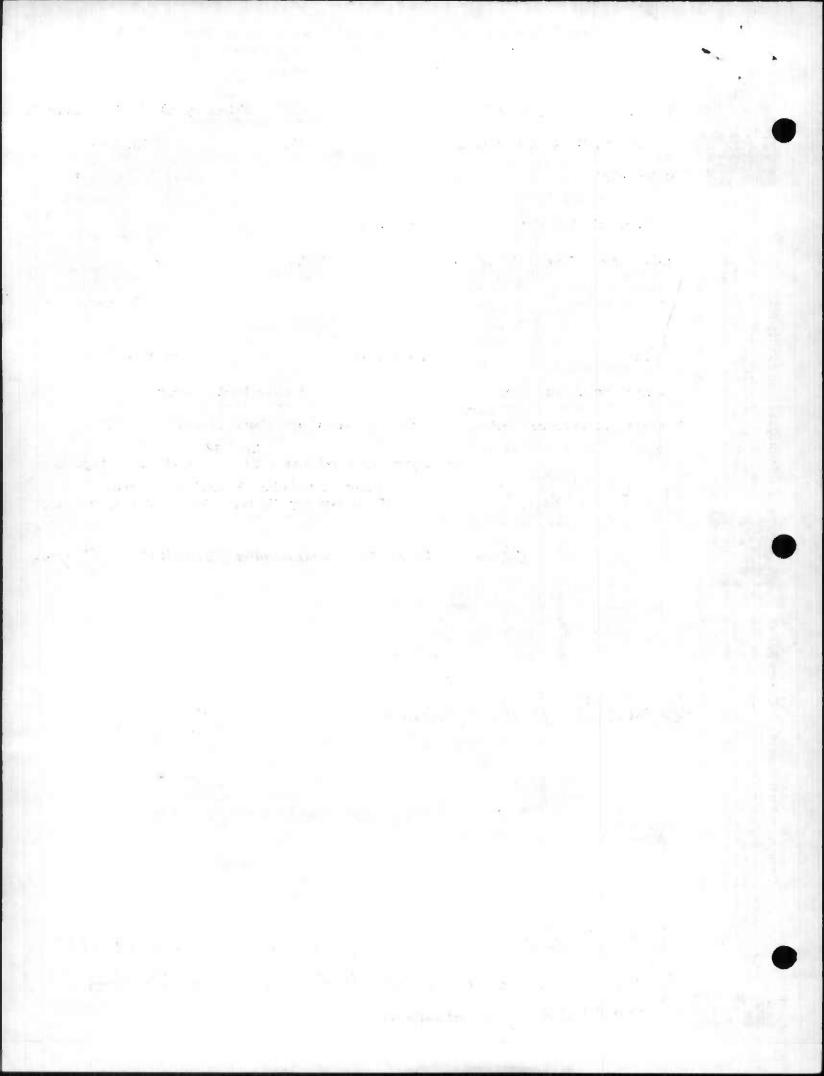
Julia Davidson

1/PCertifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. Licensa number

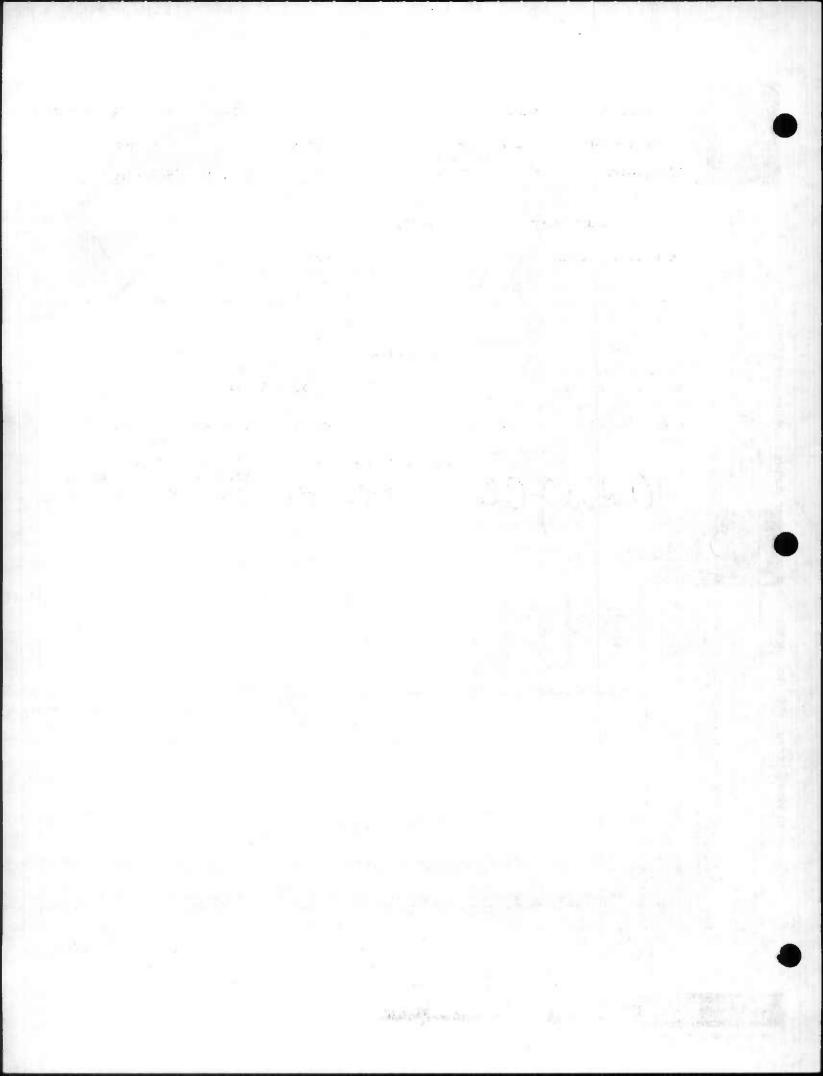
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29d. Date signad (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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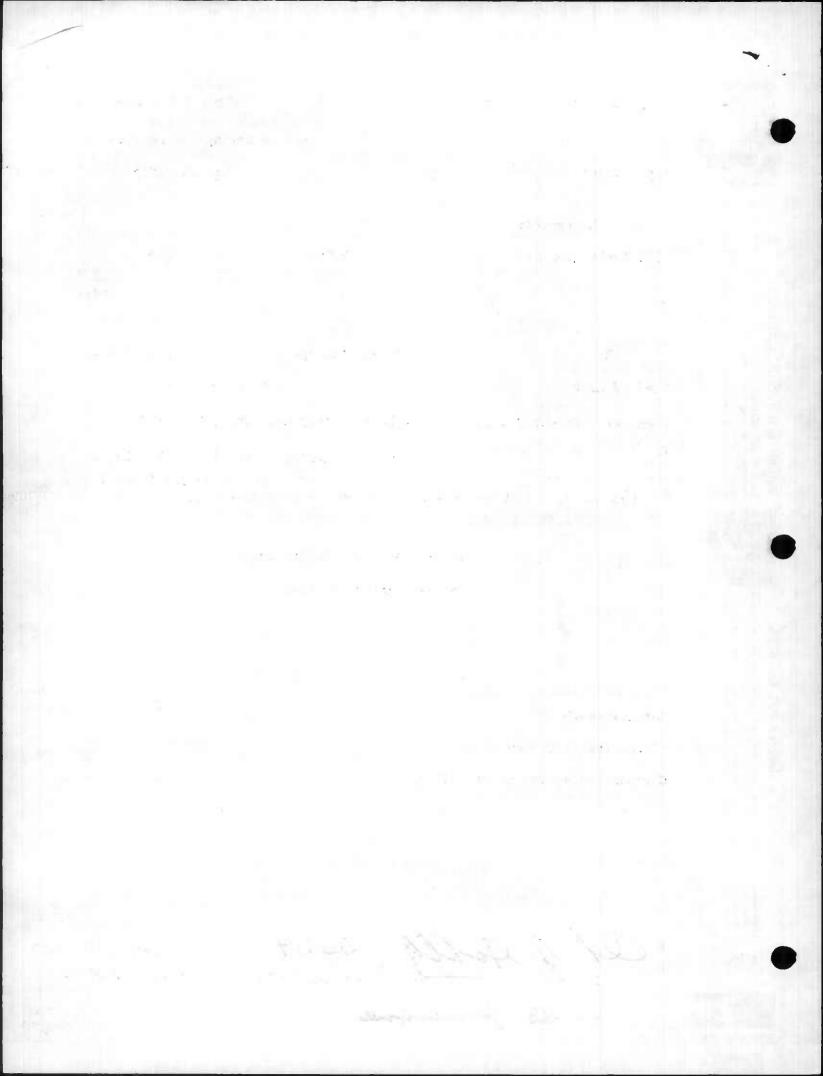


			1 Decedent's Name (First Atidal)	etl	-	Certifica	te of	Death	2. Date of Dea	eg. No.		3. Time of Death
PI	hysicia		Decedent's Name (First, Middle, La MARIAN G.	EATON					Februar		98	7:38 PM
	/Medica xamine		4a Facility Name (If not institution, giv					4b. City, Town, or	Location of Death	4c. County	of Death	
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Fu	neral		5. Social Security Number 6. S	Sex 7. Age (In yrs. last birtl	nday) If Und Month	er 1 Year Days		8. Date of Birth	Veerl	9. Birthple Count	ace (State or Foreign
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pue		- H	Usuai Residence of Decedenf 10e. State 10b. County	1	0c. City, Town	or Location					10	d. Inside City Limits
Aanyle											1 □ Yes 2 🕅	
the state of	note	Directo	Maryland Montgot 10e. Street and Number	mery	SIIVE	er Spri	Ing Code		1	0g. Citizen of V	of What Country?	
5-0020 72 hours effer death with the Maryland	4		3533 Tarkington	Ln			209	06		USA		
deat		Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er In U,S.	13. Was Dec	edent of I	Hispanic Origin? (S	Specify Yes or No-		14. Race - American Indian, Bieck, White, etc.	
o i	o lu		1 Never Married 2 Married	1 Yes 2X No			100	Specify:	ito niceri, etc.)	Specifi	7.71	
Sunor	Exe	S D	3√ Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2 ☐ No Specify 16a. Decedent's Usual Occupation						
	other than "natural", or tems 23a or 28a-f show vent, the Motical Examiner must be notified at 3e Completed by Funeral Director	ete	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's Us (Give kind of v	ual Occup vork done	pation during most of wo d)	orking	16b. Kind of Bu	usiness/Indi	ustry
within and		E	Elementary/Secondary (0-12)	Agent		Heal1	th Car	re				
filed with Hygiene.	3 6	Re C	17. Father's Name (First, Middle, Last,			Turche	52116	1	me (First, Middle,			
should be	3 4	0	Sanford Mark					Alice	Marie Do	dge		
sh sh	0 2		19a. Informant's Name/Relationship (Type, Print)					lural Route Numbe		State, Zip	Code)
6 = 6	4 7			ie Craver/Daughter 4136 Mt. Olney Ln,								
0 8 0	ry or other		20a. Method of Disposition XXBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.	20b. Place of Disposition (Name of cemetery, crematory or other place			9)			kville, MD		
Dalli Parmit. Departm	any Injury o	1	21. Signature of Funeral Servica Licer	1500	- ^	22. Name	and Addre	ess of Facility H	ines-Rina	ldi Fu	neral	Home
n 888	2 8		Alan J.	Donn	ell	118	00 N	ew Hamps	hire Ave,	Silve	r Spr	ing, MD 20
1100			23a. Part1. Enter the disease, or com shock, or heart feilure. List only	plications that caused the	e death. Do n	ot enter the m	ode of dyi	ng, such as cardia	c or respiratory arr	est,		Approximate fntervai Between
Physi	_											Onset and Death
Exan	dical niner		fmmediate Cause (Final disease or condition resulting in death)	aA	cute My	ocardi	al I	nfarctio	n			
*		ē			e to (or as a c	•					1	
petn	-transit	Examiner		0	oronary		-	sease			1	
D, executed	rial-tr	LX B	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	00	e io (oi as a c	orisequerica o						
OS/O	for use es the buria	Ca	Cause (Disease or Injury that initiated events resulting in death) Last	C. Du	e to (or as a co	onsequenca of):					
rtifice	80	200	resulting in dealing Last									
death certificate	or use	2		d								
the de	ped .	Physician/Medical	Part II. Other significant conditions of	ontributing to death but r	ot resulting In	the underlying	cause gi	ven in Part I.			ntribute to	the cause of death?
That the	detac		Cardiomyopathy						1 🗆 Y	es 2 No	3 Prob	ably 4 Unknow
requires that		d by							24a. Was a	n autopsv	24b. We	re autopsy findings
w requires	shou	lete	Mitral Insuffic	iency					perfor	med?	con	ilable prior to appletion of cause eeth?
D & 8	page 2	E										Yes 20 No
VICAL Iclan: T	ō	Mitral Insufficiency Chronic Congestive Heart Failure 25. Was cese referred to medical 24a. Was an autopsy performed? 1 Yes 2									1103 200110	
OI VIII Physician:	direct	examiner? O 1 Yes 27 No						er (Specify)			
	era!		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. T		28c. Inju Wo		28d. Describe h		-	,
Attending or deeth.	the funer	The state of the s										
DIVISION I or Attending efter deeth.	th full		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)							per or Rural	er or Rural Route Number,	
the Hospital or in 24 hours eft	pletely filled in	O										
# P 2	No.	edical	(Check only 2 Medicat Exam	ysician: To the best of n niner: On the basis of ex	amination and							
7 7 H	- = :		one)	and manner stated	4							

State Registrar 31. Date filed (Month, Day, Year) FEB 171998

30. Name and address of person was completed cause of death (Item 23e) (Type, Print)
Daniel J. Goldberg 3801 International Dr, #210, Silver Spring, MD 20906 32 Registrar's Signature

February 11, 1998



Amended #4C, Nds, Ple 2/24/98, Allegany Conty Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death FEBRUARY 21, 1998 **Physician** Ann Fields Margaret Jo 1508 /Medical 4a. Facility Nema (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Sacred Heart Hospital Allegheny Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | OCt. | 17, 1929 5. Social Sacurity Number 6. Sax Birthpleca (Stata or Foreign
 Country) 7. Aga (In yrs. last birthdey) **Funeral** 1 M 2 TF 220-26-9720 68 Yrs. Director Usual Rasidanca of Decedant 10a, Stala 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Medical Examiner must be notified at Green Spring Director Hampshire 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 26722 HC 86, Box 51 US Funeral filed within 72 hours after deeth 12. Was Dacedent Evar in U,S. Armed Forces? 1 ☐ Yas ≥ ☑No if Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Bleck, Whita, etc. 11. Maritel Status 1 Navar Married 2 Married 21215-0020 1 ☐ Yas 2 XNo Specify: by Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedant's Education 16a. Decedant's Usual Occupetion 16b. Kind of Businass/Industry permit. Peges 1 and 2 should be filed within 7. Department of Heelth and Mantel Hyglene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Media once. (Giva kind of work dona during most of working lifa. DO NOT use ratired) (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) School. Teacher's Aid Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be William F. Kesler Edna Virginia Folev 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Kimberly K. Everett, Daughter HC 86, Box 34, Green Spring, WV 26722 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cremetory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burlal 2X Cremation 3 ☐ Ramoval from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Omps Cremation Service |2/22/98 | Winchester, VA 22. Nama and Addrass of Facility Shaffer Funeral Home, Inc. 21. Signatura of Funaral Sarvica Licansae 230 E. Main St., Romney, WV Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvat Batwe Onsel and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in daath) METASTATIC BREAST CANCER 1 YEAR Examiner Dua to (or as a consequence of) Examiner MALIGNANT PLEURAL EFFUSION 6 WEEKS Attending Physician: The law requires that the death certificate be executed bunal-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that Initiated avants rasulting In death) Lest Dua to (or as a consequence of): Box 68760. physician Physician/Medicai the Dua to (or as a consequence of) signed by the e Part II. Other algniftcant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? peen has 1 Yas 2E No this certificate 1 ☐ Yas 2 € No funeral director Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No 1 npatiant Certification: To 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Panding ne Hospital or Attendin n 24 hours efter death. The Funeral Director: After pletely filled in by the fun invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be dataminad 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Certifiar 1 🗹 Cartifying Physician: To tha besi of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. Medicai To the Hosp within 24 ho To the Fune (Check only one) 2 - Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29d. Data signed (Month, Day, Year) 29b. Signature end title of certifier 29c. Licansa number FEBRUARY 21, 1998 completed cause of death (flum 23a) (Type, Print) Cumpuland Hd 21502

State Registrar 31. Date filed (Month, Day, Year) FEB 24 1998

- Cull



Thes

12 - 7:

Physicia /Medica Examina

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example Frontier Frontied at page.

Physician /Medicai Examiner

Baltimore, Maryland 21215-0020

Bland

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible

			Cert	ificate	of l	Death		4.	Reg. No.		
Decedant's Nama (First, Middle, Las								2. Date of De Month	ath Dey	Year	3. Tima of Death
	Fitzmauric	e						FEBRUA			23:41 PM
la Facility Nema (If not institution, giva	straat and number)				4			ocation of Death	4c. Count	y of Deeth	
DOCTORS COMMUNIT				If Undar 1	Vans	If Under	ham			1	FORGES
5. Social Security Number 6. Se 219–36–9839	ax 7.Aga MXM2□F	(In yrs. last i	Yrs.		Days	Hours	Min.	8. Data of Birt (Month, Da	y, Year)	COL	placa (Stata or Forais
Jsual Rasidance of Dacedant			113.		_			Dec. 4	1937	Mary	land
IOa. Stata 10b. County		10c. City, To	own or Loca	ation							10d. insida City Limit
Maryland Prince	George's	Green	nbelt								¥Wes 2□N
0e. Street and Number	1	_	-	10f. Zip C	Coda				10g. Citizen of	Whet Cou	untry?
2-B Woodland Way				207					Unite		
1. Merital Status	12. Wes Decedent E	ver in U.S.	13. W	15.		ispanic Or	igin? (Sr	pecify Yes or No			ican Indian,
1 XX avar Merried 2 ☐ Married	Armed Forces? 1 ☐ Yes XXN					n, Mexica	n, Puerto	pecify Yes or No Rican, atc.)	Ble	ock, White	, etc.
3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Yeer or Detas:		11	□ Yas 2	No	Specify.			Speci	fy: V	White
15. Dacedant's Ed		16	Se. Deceda	nt's Usual	Occup	ation			16b. Kind of E	Businass/li	ndustry
(Spacify only highest grad	da complated) Collega (1-4or 5-		(Give k.	ind of work O NOT use	dona d	du <i>ring</i> mos ()	t of wor	king	Univ.	of Ma	aryland
Elementery/Secondery (0-12)	Conega (1-40) 5-		Posta	1 Cle	rk				Post O	ffice	9
7. Fathar's Name (First, Middle, Last)						18. Moth	ar's Nam	ne (First, Middla,	Maidan Suma	ma)	
Joseph L	eo	Fitzma	auric	е		Maı	У	М.	T	orzev	vski
19e, Informant's Name/Relationship (7)	ype, Print)	1	9b. Mailing	Address (Street	end Numb	er or Ru	ral Route Numb	er, City or Town	, Stata, Z	ip Coda)
Mary M. Fitzmaur:	ice (mothe	er)	sam	e as	#10						
Oa. Method of Disposition		20b. Place	of Dispositary, crami	tion (Name	a of	al.		Deta	20c. Location	- City or T	Town, Stata
Morial 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify							~ 2	/18/199	Silve	r Spi	ring, Mary
1. Signafure of Funeral Service Licent	199		22.	Nama and	Addra	s of Fecil	ity				
Alter On 1/1	Smarker.	OL						t Funera			
23a. Pert1. Enter the disease, or comp	Dr affiche	Do dooth D								Mary	/land 2070
shock, or haart failura. List order	one cause on each lin	e	O LIGH BINE	110 III040	or ugar	9, 100, 41		or respectively of			Intervel Between Onsat and Death
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disaasa or condition asulting in daath)	. Athero				10	100	WSC	cultur	Msec	uc	
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Sequentially list conditions, fleny, leading to immediata seusa. Enter Undarlying		Dua to (or as	a consequ	ance of):						1	
ceusa. Enter Undarlying Cause (Disease or injury that initiated avants	C										
esulting in death) Last		Due to (or es	e consaqu	ence of):							
	d										
Part II. Other significant conditions co	intributing to death bu	t not rasulting	n the und	darlying ce	usa giv	an in Part	1.				to the cause of dea
								12	Yes 2□No	3 □ Pr	obably 4 Unkn
								240 18/00	an autopsy	24h V	Vara autopsy finding
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											of death?
								192	Yes 2□No	1	19 Yas 2 No
Was cesa raferrad to madicel axaminar?		_			1-		e of Dee	eth (Check only o	one)		
1 Yes 2 No	Hospital:	1	Outpatient			4 L N	ursing H	oma 5 Rasi			cify)
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2 Accidant invastigation				М		Yas 2□	No				
3 ☐ Suicida 6 ☐ Could not be	28a. Plece of Inju building, etc.	ry - At home,	farm, stre	et, factory,	office			28f. Location (City or To	Street and Nun wn, Stata)	nber or Ru	and the san Alice has
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by tha funaral director, page 2 should be detached for use as the bunal-transit

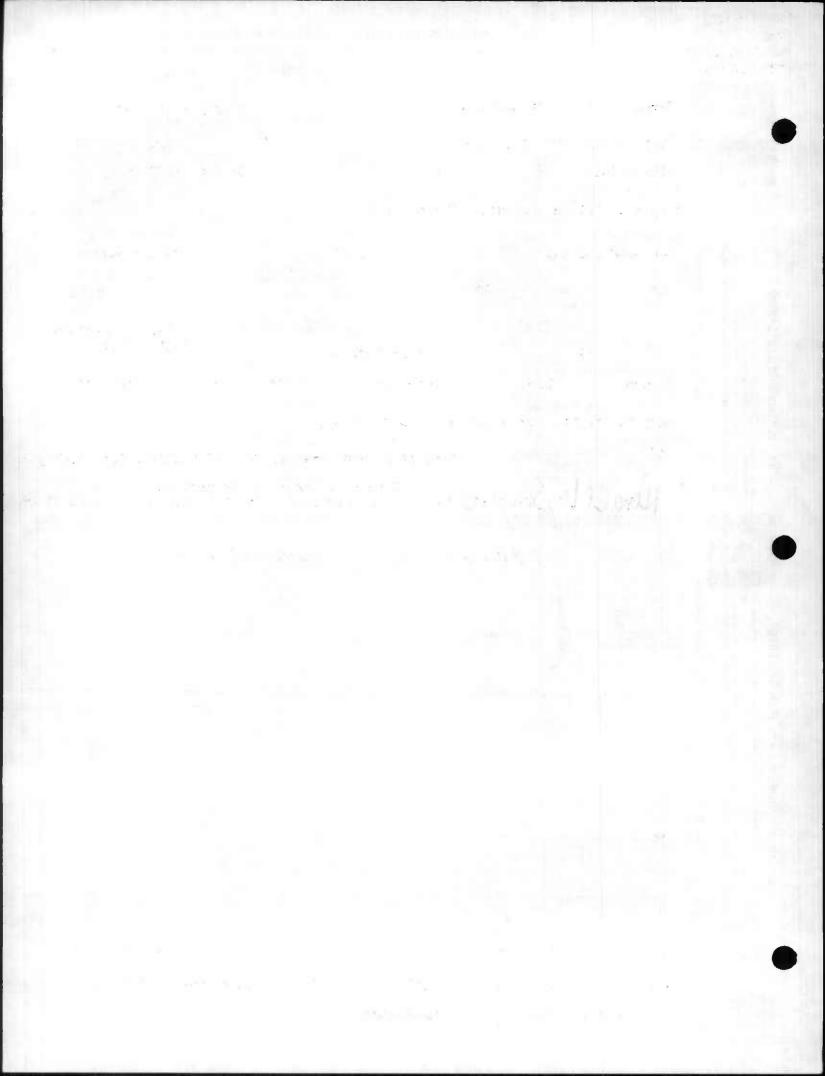
Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Day, Year)
FEB 17 1998

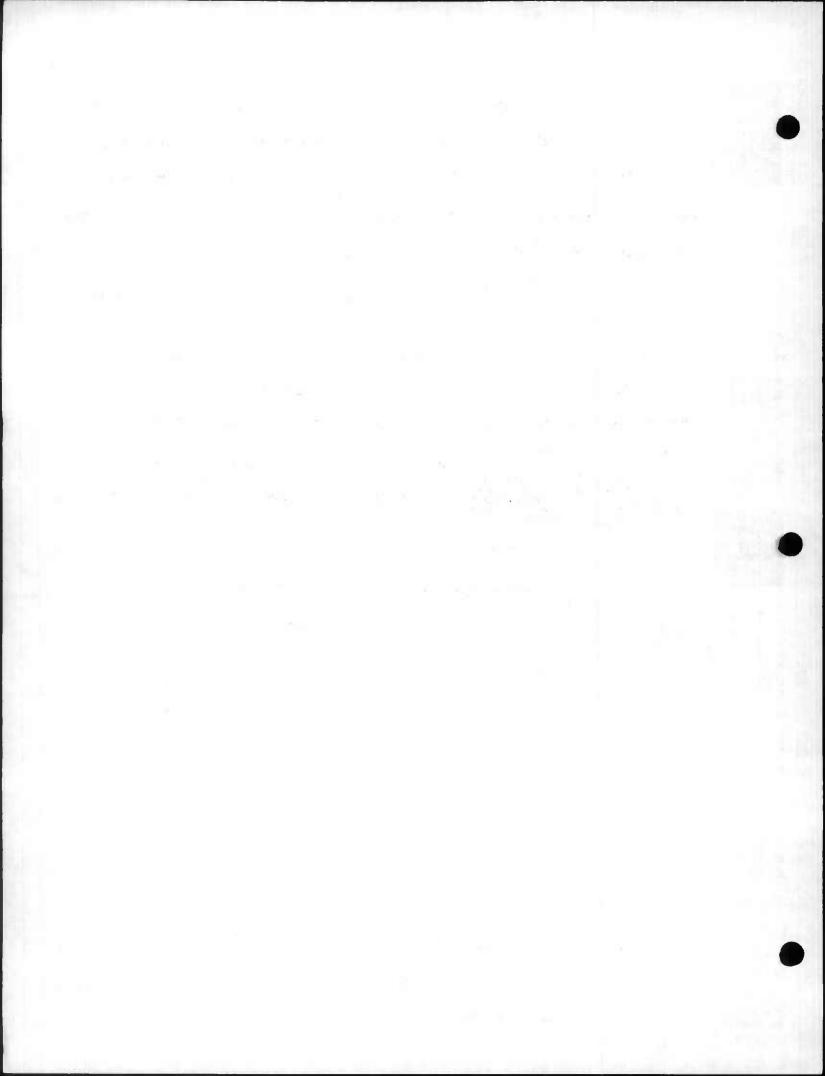
30. Nama and addrass of person who complated ceusa of death (Itam 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201
32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 9 8 0 6 7 7

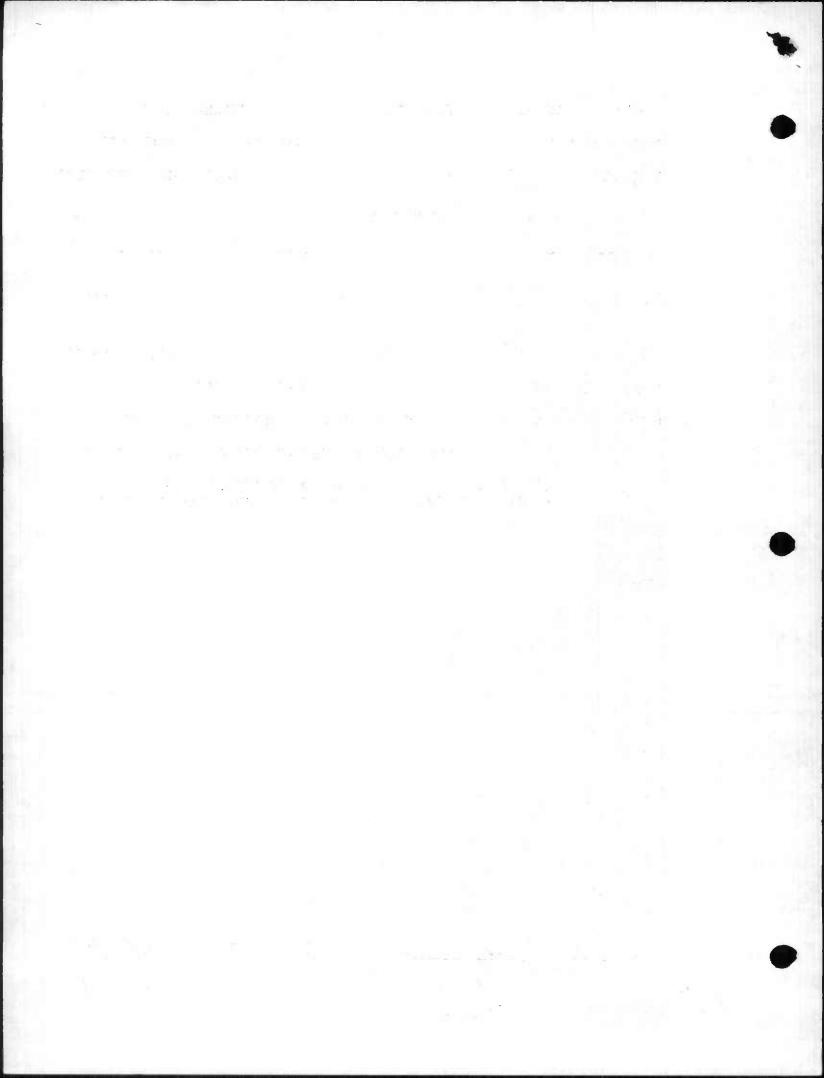
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			Spring House	-	2201 Cols	ton S	Stree	t		Silve:	r Sprin	ng	Mo	ntgome	ry	
	Funeral Director		5. Social Sacurity Number 067–40–9440		Sax 7. Ag 1□ M 2∭ F	e (In yrs. 91	last birthde Yrs	Mon	Indar 1 Yaei hths Days	If Unda Hours		Data of Birt (Month, De)	y, Year)	9. Bir Co D6 Rus	thplace (Stete puntry) SSIA	or Foreign
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	he Maryl 28a-f sho offred a	ector	Maryland Mont	gome	ery		ver	Spri	ng						1X Yes	s 2 No
	ath with t	Funeral Director	10e. Street and Number 2201 Colston	St.	#207				f. Zip Coda 20910				U.S.	an of Whet Co A	ountry?	
21215-0020	be filed within 72 hours efter death with the Maryland nat Hyglene. d other than "natural", or itams 23a or 28a-f show event, the Medical Examinat must be notified at	by	11. Maritai Status 1 ☐ Navar Marriad 2 ☐ I 3 🖾 Widowed 4 ☐ Divor		12. Was Dacedent Armed Forces? 1 Yes 2 1 If Yas, Giva Yeer or Datas:		S. 1		ecedent of specify Cul as 2X No		rigin? (Specify an, Puerto Rica /:	Yas or No- an, atc.)		4. Reca - Ame Bleck, Whit Specify: Wh	la, atc.	
5-0	72 h	etec	15. Dece (Specify only his	dent's E	ducation		16e. De	cadent's	Usual Occu	pation	st of working		16b. Kin	d of Businass	/Industry	
121	d 2 should be filled within h end Mental Hygiene. 7 is marked other than ° traumatic event, the Mer	Completed	Elamentery/Secondary (0-1		Coilege (1-4or 5	+)	life	DO NO	OT use retire	ed)	st of working					
	ygiel ygiel rt, fr		12				Ho	ısew:	ife					Home		
and	od a b	Be	17. Father's Name (First, Mide	zie, Lest)						ner's Neme (Fi			Sumeme)		
7	Mer Mer	2	Mendel Matz								ah Goni					
Maryland	12 sh h end r is n traun		19a. Informent's Name/Ralati		, ,						ber or Rurel Ro				Zip Code)	
	m 2 her		Barbara Fuchs 20a. Method of Disposition	GIS	itt-Daugnte		D14			. INW	Washin	ata			T 01-1-	
Baltimore,	permit. Pages 1 and 2 should Department of Haalth end Men Important: if Item 27 is marke any Injury or other traumatic once.		1 X Burial 2 ☐ Cramati 4 ☐ Donation 5 ☐ Otha			C	th Da	remetory	or other ple	ece)	1			ation - City or		
Ball	Depart Import any In		21. Signature of Eugenral Seas	Ze you	1000	00					^{lity} Josep Ave. N					16
			23a. Part1. Entar the disaase shock, or heert failura.	, or com	plications that caused	tha daati	n. Do not	enter the	moda of dy	ing, such as	s cardiac or ra	spiratory ar	rast,		Approxima	ıta
0	Physician		snock, or neert failura.	List only											Interval Be Onset end	
	/Medical		Immediate Ceusa (Final disease or condition		a. Card	in	ak	400	+						Sund.	den .
	Examiner		rasulting in daath)			Due to la		POGLIOPOS	of).						ound	The same
_		ner			Anstro	reto	111	K	shot	Fac	elure				Suda 12 m	11
	tificate be executed ig physician and as the buriel-transit	Examiner	Sequentially list conditions.		b. — 4	Due to (or	es a con:	aquenca	of):		on				12 m	onthe
o,	an ar		Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events	J	mus	nake	1:1	1	Inter	etis	on)					
68760,	ysicl ne bu	Medical	Causa (Disaase or injury thet initieted events rasulting In death) Last	5	V		es a cons									
99	e as th	Med	rasuming in death, cast													
Box	attendin for use				d								-			
	death e atte	sicia	Part II. Other algnificant cond	titlone o	ontributing to death bu	ıt not rası	ulting in the	underlyi	ing cause g	iven In Pert	1.	23b. Did t	obacco u	ae contribute	to the cause	of death?
S, P.O	es that the death certificate be executed igned by the attending physician and be datached for use as the bunel-transit	by Physician										101	res 2%	(No 3□P	robably 4] Unknown
Records,	s been s 2 should	Completed t										24a. Was a	an autops med?		Were eutopsy aveileble prior compiation of of daath?	to
<u> </u>	9 - 6	Ю										1□ Y	as 2K	No	1 Yas 2	No
Vital	iclan: The certificate rector, pag	Be	25. Was case referred to med	ical					7.1	28. Plac	e of Deeth (C	heck only o	ne)			_
>	Q 50 Z	70	examinar? 1 ☐ Yas 2 ☐ No		Hospital: 1 ☐ inpatie	nt 2 🗆	ER/Outpat	iant 3	DOA O	har: 4 N	lursing Home	5 Resid	ence 6	☐Other (Spe	cify)	
100	D 0 0		27. Manner of Deeth	dia m	28a. Date of injui (Month, De)	y (Year)	28b. Time Injur		28c. Inju			Dascribe h				
0	Attending F or death. ector: After by the funer	atio	1 Naturai 5 ☐ Per 2 ☐ Accidant inv	astigation		Tour)	111101	М		Yas 2] No					
Division	al or Attendin s after death. il Director: Aft ed in by the fur	27. Manner of Deeth 1								28f. Location (Street end Number or Rural Route Number, City or Town, Stete)				m <i>ber</i> ,		
	To the Hospital or / within 24 hours after To the Funeral Dire completaly filled in b	edicai (29a. Certifiar 12 Carti (Check only 2 Medi-	** only 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death or					nd place, and ath occurred a	d place, and dua to the cause(s) and menner as stated. the occurred at the time, date end place, end due to the cause (s)			s stated. e to tha cause((s)		
	Within To th	Me	29b. Signatura and title of cartifiar								29d. Date signed (Month, Dey, Year)					
			Carol	Z.	83 Ender	, n	1/2)		mh.	017	7615	md)	Febru	uary :	15, 199	8
	10		30. Name and addrass of pars	on who	completed cause of de	eath (Itam	23a) (Tvr	e. Print)	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	/						
			CAROL L. BE		ER 1151) /	Ld (GFOI	ROPTA	WN .	Rd.	Rock	ville	md	2085	2.
	Sta	ite	31. Data filad (Month, Day, Ye		32. Registra	r's Signa	tura		J					1	. ~~00	
	516	ile.		100		Karil.	. 30									



State of Maryland / Department of Health and Mental Hygiene

enc	d #7, 2	/18	/97,BMW,Montg. Co	,	Ce	ertificate d	of Death	R	eg. No.	U	0/	13
1	Physic	ian	Decedent's Neme (First, Middle, Last)					2. Dete of Deer Month	Dey	Yeer		me of Death
	/Medi	cal	JULIA MAR		FERNANDE	Z	4b. City, Town, or L	FEBRUAR	Y 16,19			L5 PM
7	Exami	ier	WILSON HEALTH CAP				GAITHERS		MONTO			
	Funeral Director		5. Sociel Security Number 6. Sec		yrs. iest birthdej 91 Yrs.	Months De	1		Year)	9. Birth		tete or Fore
	wor.		10e. Stete 10b. County	100	c. City, Town or I	ocation					10d. Insi	de City Limi
	the Meryler 26a-f show	ctor	MD. MONTGOME	ERY	GAITHERS	SBURG					1,13	Yes 2□
	or 26	Funeral Director	10e. Street and Number			10f. Zip Cod			0g. Citizen of 1			
	seth w	era	211 RUSSELL AVENU	JE 12. Wes Decedent Ever	in HC 42	Was Doodent	20877		UNITED	STAT ce - Ameri		20
21215-0020	be filed within 72 hours efter deeth with the Meryland tel Hyglene. I other than "natural; or items 23a or 28a-f show event, the Medical Exercites roughly an event,	by	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	110,3.	If Yes, specify (of Hispanic Origin? (Sp Cuben, Mexican, Puerto No <i>Specify</i> :	Rican, etc.)		ck, White		
5-0	n 72 hours "natural",	eted	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dec	edent's Usuel Oc e kind of work do	ccupation one during most of work stired)	king	16b. Kind of B	usiness/lr	ndustry	
12	within ene. then	Completed	Elementery/Secondery (0-12)	College (1-4or 5+)		ODO NOT USO 76 CRETARY	tired)		U.S. (COVE	DNMEN	ı.T
	Hygien Other	CC	17. Fether's Neme (First, Middle, Last)	1	3E (CKETAKT	18. Mother's Nem	ne (First, Middle, I			CHIPE	41
lan	Afentel Ked c	To Be	MICHAEL FERNANDE	ΞZ			GRACE	SMERAL	DI			
Maryland	permit. Pages 1 and 2 should be filed within 72 h Department of Heath end Mentel Hyglene. Important: if item 37 is marked other than "natur any injury or other traumetic event, pra Medical SARS.		19e. Informant's Neme/Reletionship (Ty		1	_	reet end Number or Ru		-		ip Code)	
	l and fealth m 27 har tr		RICHARD D. THOMPSON				ROAD, BALT					
Jor	nt of H		20e. Method of Disposition 1 ☐ Buriel 2 ☑Cremetion 3 ☐R	emovel from Stete	METROPOL	position (Neme o ematory or other _ I TAN CR	nlanal		20c. Location - ALEXANI			
Baltimore,	nit. Partme		4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service License		-							
ä	Depa Impo any la		muriel	W-12re	4. 84		dress of Eacility			0000	0.0	
	ć		23a. Pert1. Enter the disease, or complishock, or heart feilure. List only or	cetions thet caused the	deeth. Do not e	nter the mode of	dying, such as cardiec	or respiretory error	E, MU.	2088	Approx	ximate
86	Physician		snock, or neart lellure. List only or	le ceuse on each line.						1	Onset	and Deeth
7	/Medical Examiner		Immediate Cause (Finel disease or condition	Pneur	monitis						do	45
	LAGIIIIICI	_	resulting In death)		to (or es a conse	equence of):				1		/
	ted insit	edical Examiner	_ b									
ó	exection and and right-free	Еха	Sequentieily list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due	to (or es a conse	equence or):				[
68760,	cate be executed physician and s the bunal-transit	lical	Cause (Diseese or Injury that initieted events resulting in death) Last	Due	to (or es a conse	quenca of):						
	ing ph	Med	Toodhing in doaling East							i		
Box	The law requires that the deeth certificate be executed the has been signed by the ettending physician and page 2 should be deteched for use as the burial-transit	Physician/M								i		
P.O.	res thet the de signed by the e I be deteched i	nysic	Part II. Other significant conditions con			underlying cause	given in Pert I.		bacco use co			
	s thet	y Pt	Congestive He	art Fail	re			1 U Y	es 2 No	3□ Pro	bably	4 TOnkno
rds	requires been sig should b	Completed by						24a. Wes e		24b. V	Vere auto	psy findings
ecc	aw re	plet						political		0	ompletion deeth?	n of cause
<u>=</u>		Con						1 □ Ye	s 2 No	1	☐ Yes	2□ No
Vita	Attending Physician: The rideath. octor: After this certificate by the funeral director, par	Be	25. Wes case referred to medical examiner?	ospitel:			26. Plece of Dea	th (Check only on	Θ)			
To	Phys ral di	1: 10	1 ☐ Yes 2 ☐ No 27. Menner Death	1 L Inpatient	2 ER/Outpation		4 ☐ Nursing H	ome 5 Reside			ify)	
on	ding it.	ition	1 Naturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Yea	ar) Injury		njury at Work? 1 □ Yes 2 □ No	204. 0 000/100 110	in anjury coods			
Division of Vital Records,	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	Certification:	3 Sulcide 6 Could not be determined	28e. Plece of Injury - building, etc. (S)	At home, ferm, s	treet, fectory, off	ice	28f. Location (St City or Town	reet and Numb 1, Stete)	ber or Rui	ral Route	Number,
	Hospi 24 hou Funer tely fill	edical	(Check only 2 Medical Examin	ician: To the best of my er: On the basis of exa	knowledge, dea minetion end/or i	th occurred at th	e time, dete end place, ny opinion, deeth occur	end due to the co	use(s) end ma	anner as	steted. to the ca	use(s)
	ithin 2 o the	Med	one) 29b. Signeture end title of certifier	end menner steted.			ense number		9d. Dete signe			
			17/12	///								
	S		30. Neme and address of person who co	mpleted cause of deeth	(Item 23a) (Type	, Print)	1/3223	7		, , ,	-	
			Lee Jonethan	proste	hm J	-530 L	D3335	· Ane	Chang (Ch	~ m	0
			Of Data Blad Afrada Day Vall	00 0 11	DI .							

Registrar

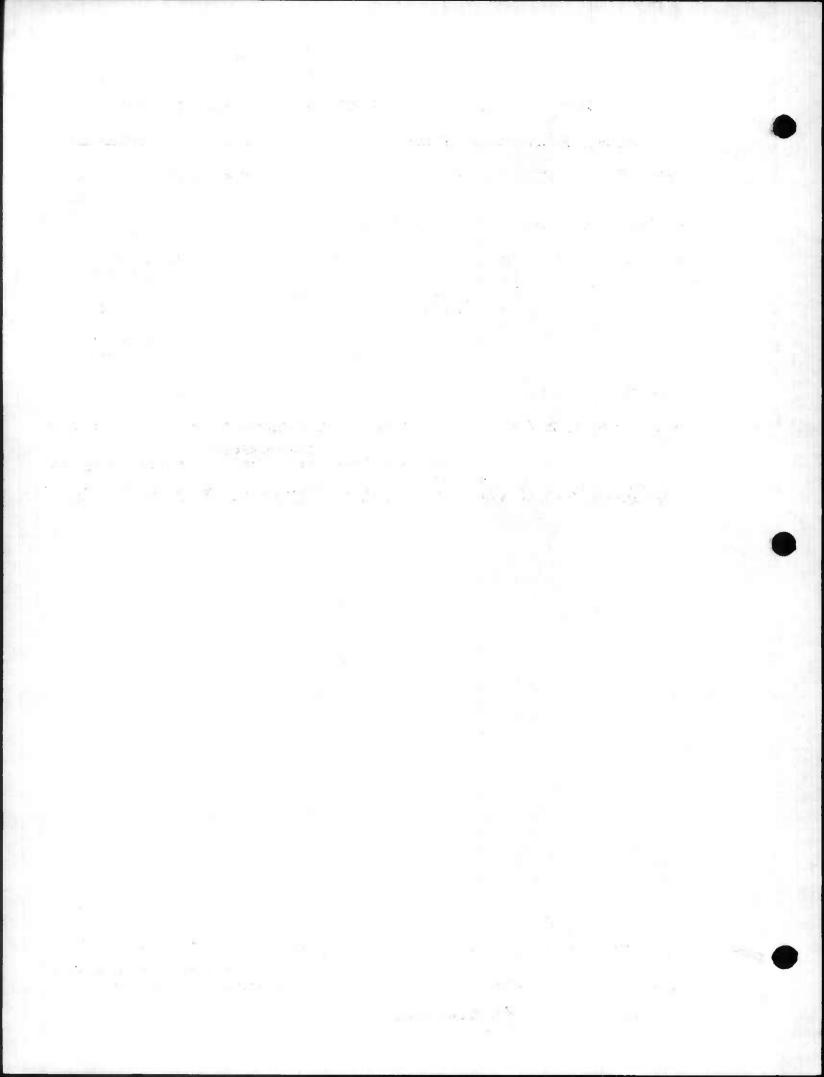


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month FEB **Physician** REED Μ. FAWELL, JR. 1998 14 2:40 AM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** 1⊠M 2□F Yrs. Director 252-07-5441 85 May 26, 1912 California Usual Residance of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinat must be notified at Director 1 ☐ Yas 2 No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8101 Connecticut Avenue, #N607 United States 20815 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Introcrant: If tem 27 is marked other than "natural", or free any Injury or other traumatic avant 1 X Yas 2 Norld If Yas, Giva World Yaar or Datas: War 1 ☐ Nevar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Sacondery (0-12) United States Coilage (1-4or 5+) Colonel Marine Corps 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maiden Sumama) Be Reed M. Fawell, Sr. Eleanor Matthews 19e. informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Reed M. Fawell, III / son 6809 Canal Bridge Court, Potomac, Maryland 20854 20b. Place of Disposition (Nama of cematary, cramatory or other place) February 18, 1998 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility M00831 Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. sourence 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batw **Physician** /Medical Immediata Cause (Final PNEUMONIA disaasa or condition resulting in daath) Examiner Due to (or as a consequence of) attending physicien end for use as the bunel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to complation of causa of death? Completed peed page 2 s 1 Yas 20 No certificate 1 Yas 2 No Division of Vital Hospital or Attending Physician: 25. Was case refarred to medical Be 28. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Rasidance 8 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred After 1 Naturai 5 Pending Invastigation death. 1 Yas 2 No ofter death Director: A 2 Accidant 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida To the Hospital or within 24 hours effer To the Funeral Direcompletely filled in b 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Example: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the Medical 29a. Certifier (Check only one) itner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifing 29c. Licansa number 29d. Data signed (Month, Day, Year) FBB 17, 1998 RES-000 M.D. ne and addrass of barson who completed cause of death (itam 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER TADEN, BETHESDA MD 20889-5600 31. Data filad (Month, Day, Year) Registrar's Signatura State FEB 181999 Seviden

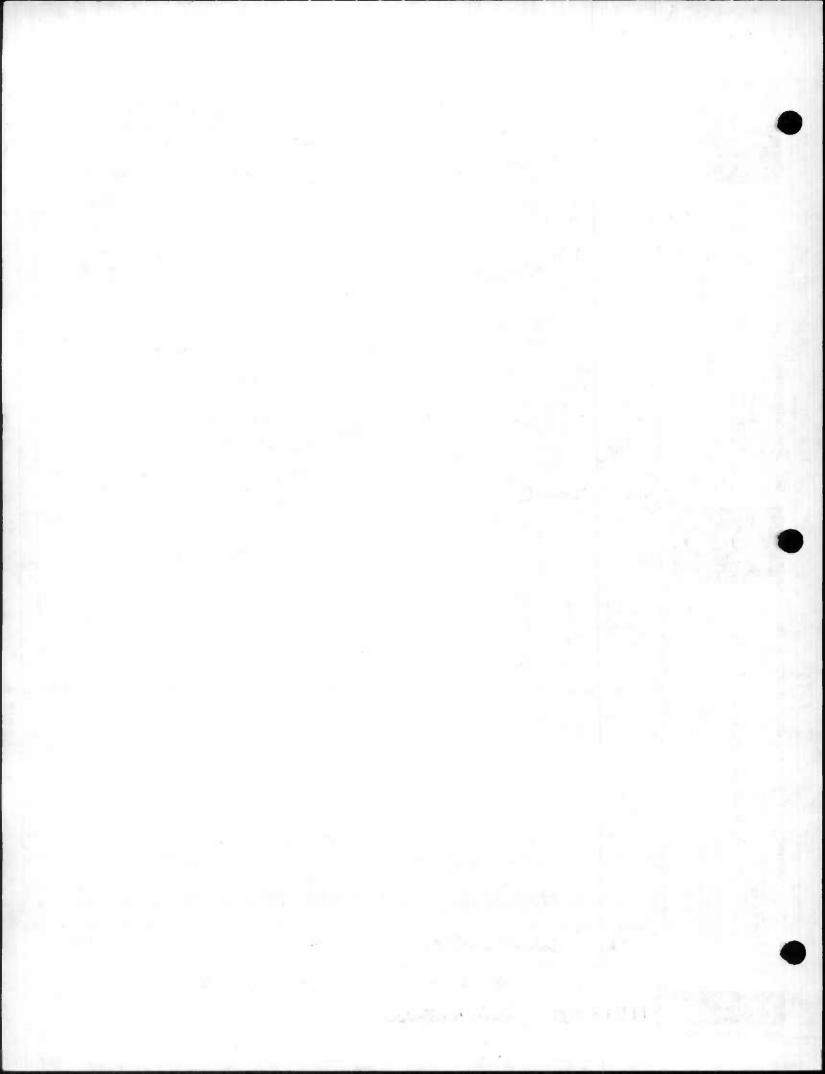
Registrar



State of Maryland / Department of Health and Mental Hygiene 9 8 0 6 7

REF BUT		Decedent's Name (First, Middle, La	st)		Cei	tificate of	Death		P. Dete of Dee	eg. No.		3. Time of D	Death
Physician	_		Lota L.	Fair	a11			1	Month Februar	y 13,	Yeer 1 Q Q Q	5:00	
/Medical Examiner	-	4e. Fecility Neme (If not institution, giv	e street and number)				4b. City, To		ation of Deeth	y 13,		3.00	AIT
LXammor		Carriage Hill-					Beth	nesda			gomer	37	
Funeral	٦	5. Sociel Security Number 6. 5		e (In yrs. le	st birthday)	If Under 1 Yea Months Deys	If Under		B. Date of Birth (Month, Dey		-	y elece (State or i etry)	Foreig
Director	1	220-42-0039	□M 2፟ F	81	Yrs.	Working Boy.	riours	S	ept. 6	1916	Tex	as	
ž	-	Usuel Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cetion					1.	0d. Inside City	. Limit
de la la	5	Maryland Montgome	221								,	1 ☐ Yes 2	
or 28a-f	5	10e. Street end Number	- L y		Kensi	10f. Zip Code			1	Og. Citizen of	What Coun	atry?	
38		3811 Everett Str	eet			2089	5			nited		-	
r items 23e	2	11. Marital Status	12. Was Decedent	Ever in U,S	. 13. V	Vas Decedent of Yes, specify Cul		gin? (Spec			14. Race - American Indien,		
by by	2	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 2 3 1 If Yes, Give Yeer or Dates:			Yes, specify Cul			ican, etc.)		Bleck, White, etc. Specify: White		
ygrene. Tr, tre Medical I	2	15. Decedent's Ed	ucation		16a. Deced	ent's Usuel Occu	petion			16b. Kind of B			
than "n than "n the Med	2	(Specify only highest gra	de completed) College (1-4or 5	5+)	life. E	kind of work done OO NOT use retin	during most ed)	t of working	,				
off, the Man	5	12			Stat	tisticia	n			World 1	Bank		
1 5 E	מ	17. Fether's Name (First, Middle, Lest)						's Name (First, Middle, Malden Sumeme)					
marked o	2	19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number of											
200													
	-	19e. Informent's Neme/Reletionship (Type, Print) Susan F.N. Coleman/Daughter 19b. Mailing Address (Street end Number or Rure 1604 D Street, S.E., Wa										0003	
		1 ☐ Buriel 2 ☑ Cremetion 3 ☐		cen	netery, crem	etory or other pla	reb.	. 15,	1998	20c. Location			
njury	-	4 Donetion 5 Other (Specifical Services Licenter)	*	Mon		y Crema				ethesda			
important: if item any injury or other once.		21. Signature of Funeral Service Licen	× C	M001	Rối 98 R	Name end Addr Dert A. 557 Wisc ethesda,	Pumphr Onsin	ey Fu Avenu	neral	Home/Be	Cha	da-Chev se, Inc	/y
		23e. Pert1. Enter on diseese, or compshock, or helin feilure. List only	olications thet caused	the deeth.	Do not ente	er the mode of dy	ing, such es	cardiac or	respiretory err	est,		Approximete Intervel Betwe	
physician and s the bunal-transit		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	b	alize	d Arte	rioscle	rosis						
use a		thet initiated events resulting in deeth) Last	d	Due to (or e	s e consequ	ence of):							
d by the attendi		Pert II. Other significant conditions co	ntributing to death bu	ut not resulti	ing in the un	derlving cause g	ven in Pert I.		23b. Did to	bacco use co	ntribute to	the causa of	death
by th		Diabetes Mellit										ably 4 Un	
be de		Diabetes Mellit	us					_					
should should	-								24e. Wes e		eve	ere autopsy find sileble prior to apletion of cau death?	-
oage 2									1 □ Y€	s 2⊠No	1	Yes 2 No	0
certificate rector, page		25. Wes case referred to medical					26. Piece	of Deeth /	Check only on		l		
this ce al direct		exeminer? 1 ☐ Yes 2⊠ No	Hospitel: 1 ☐ Inpaţie	nt 2 EF	VOutpatient	3□ DOA Ot	200			nce 6 Oth	er (Specify	,)	
ther th		27. Menner of Deeth 1 ☑ Natural 5 ☐ Pending	28a. Dete of Injur (Month, Dey	Year) 2	8b. Time of Injury	28c. Inju			-	w injury occur			
or: A the fu		2 ☐ Accident Investigation					Yes 2 N	No					
To the Funeral Director: After I completely filled in by the funer medical Certification:		3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Inju building, etc	iry - At hom . (Specify)	e, farm, stre	et, fectory, office		28	f. Location (St. City or Town		oer or Rural	Route Numbe	ir,
To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com									eted. tha ceuse(s)				
Samp dia	S Particular and the second se							d. Date signe	d (Month, E	Dey, Year)	-		
		16.1	Souther	mi	5	D11	29c. License number 29d. Date signed (Month, Dey, Year) D11024 February 13, 1998						
0	3	io. Name and adduss of person who o	ompleted cause of de	eth (Item 2	3e) (Type P	Print)							
	1	John B. Umhau, M.				Avenue	Chev	v Cha	se. Ma	rvland	20815	5	
		-		-				,	,,				

DHMH 16 Rev 6/95



Physician /Medical Examiner

Funeral Director

permit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.
Important: If term 77 is marked other than "natural", or items 23s or 23s-f show any injury or other traumatic event, the Medical Examiner mail be notified at

Be Completed by Funeral Director

To

1 Nevar Married 2 Memfed 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No No 1 Yes 2 No No 1 Yes 2 No No No No No No No		Pleas	se Type or							-		_	ible.			-
Decedent Name (Pirst, Models, Last)			State	i iviai yiai		•				neritai m	, ,	9	8	06	778	
Thomas Lercy Perwick, Sr. February 18 1998 1:00 AM	1. Decedant's Name	(First, Middle,	Last)								eath		2010	3. T	ima of Dea	ith
A Eachly Name of institution, give street and number) St. Mary's Hospital St. Mary's Social Security Number 220-16-3692 190	Thomas L	eroy Fe	enwick, S	r.										8 1:	00 A	M
Social Security Number 220—16—6692 6. Sar 7. Aga (in yrs. last birtholay) 10 det 1 Year				mber)				4b. City, T	own, or L		-					
Mary Section	St. Mary	's Hosp	oital					Leon	ardt	own		st.	Mar	y's		
Such Residence of Decedent See. State Soc. State Soc. State Soc. State Soc. State Soc. State Soc. State Soc. State Soc. State Soc. State Soc. State Soc. State Soc. State Soc. Mary's Park Hall 100. City, Town or Location Park Hall 101. Zip Code 20667 United States 114. Roce - American ridear, states 115. Was Decedent of Hispenic Origin? (Speedy Yas or Not 19 City as						*				8. Data of B (Month, D January	irth Pay Yea 7 2,	1927	9. Bir	thplaca (Sountry)	State or Fo	raign
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The Street and Number 17718 Park Hall Road 10. Zip Code 20667 10. Cip Code 20667 United States 10. Larinat Status 11. Nariar Status 11. Nariar Status 12. Was Decodent Evar in U.S. Armed Forces? 13. Specify Cuban, Mexican, Proposition, atc.) 15. Decederative Education (Specify only infringer grands completed) 16. Decederative Education (Specify only infringer grands completed) 16. Decederative Education (Specify only infringer grands completed) 16. Decederative Education (Specify only infringer grands completed) 16. Montar's Name (First, Middle, Maidle, Last) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidle, Summaria) 18. Mother's Name (First, Middle, Maidle, Summaria) 20. Informative Name Name (First, Middle, Maidle, Summaria) 20. Informative Name Name (First, Middle, Maidle, Summaria) 20. Informative Name Name (First, Middle, Maidle, Summaria) 20. Informative Name Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle, Maidle, Summaria) 20. Informative Name (First, Middle, Maidle														1-0-	1777	
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Laborer Construction	(Speci	fy only highest	grada complatad)	1.4005:)	(G	iva ki	nd of work don	a during mos	st of work	ing	16b.	Kind of B	Businass	/Industry		
Phomas Ferwick 9a. Informant's Name/Ralationship (Type, Print) 2aisy E. Ferwick, Wife P.O. Box 292, Park Hall, Maryland 20667 2b. Mathod of Disposition 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) P.O. Box 292, Park Hall, Maryland 20667 2b. Mathod of Disposition 1 Burial 2 Cremetion 3 Ramoval from Stata 4 Conation 5 Cohar (Specify) Charles Memorial Gardens 2/21/98 Leonardtown, Maryland 2c. Nama and Address of Facility Brinsfield Funeral Home, P.A. 2c. Nama and Address of Racility Brinsfield Funeral Home, P.A. 2c. Nama and Address of Racility Brinsfield Funeral Home, P.A. 2c. Nama and Address of Racility Brinsfield Funeral Home, P.A. 2c. Nama and Address of Racility Brinsfield Funeral Home, P.A. 2c. Nama and Address of Racility Brinsfield Funeral Home, P.A. 2c. Nama and Address of Racility Brinsfield Funeral Home, P.A. 2c. Nama and Address of Racility Brinsfield Funeral Home, P.A. 2c. Nama and Address of Racility Brinsfield Funeral Home, P.A. 2c. Nama and Address of Racility Brinsfield Funeral Home, P.A. 2c. Location - City or Town, Stata 2c. Locatio	6	idaly (0°12)	Collega (1-40(54)	I	Lab	orer				C	onst	ruct	ion		
9a. Informant's Name/Ralationship (Type, Print) Alaisy E. Fenwick, Wife P.O. Box 292, Park Hall, Maryland 20667 2a. Method of Disposition 1 Burial 2 Cremetion 3 Ramoval from Stata (Donation 5 Cohar (Specify) 2b. Place of Disposition (Name of Cemeration 5 Cohar (Specify) 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Address of Facility Brinsfield Funeral Home, P.A. 2c. Name and Add			nst)									an Sumai	ma)			
P.O. Box 292, Park Hall, Maryland 20667 Data Buria 2 Cremetion 3 Famoval from Stata 20b. Place of Disposition (Marne of Cemeralary, Gramatory or other place) 2/21/98 Leonardtown, Maryland 2/21	19a. Informant's Na	me/Ralationshi	o (Type, Print)		19b. M	ailing	Addrass (Strai					or Town	. Stata.	Zip Coda)		
20. Mathod of Disposition 1				Wife										-,,		
Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20550 Approximate shock, or heart failure. List only one cause on each line. Approximate for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dying, such as cardiac or respiratory errest. Approximate for the mode of dispiration of cause of death? 1 Yes 2 No 3 Probably 4 Unknown or all the mode of dying error of cause of death? 1 Yes 2 No 3 Probably 4 Unknown or all the mode of death? 1 Yes 2 No 3 Probably 4 Unknown or all the mode of death? 1 Yes 2 No 3 Probably 4 Unknown or all the mode of death? 1 Yes 2 No 3 Probably 4 Unknown or all the mode	20a. Mathod of Disp 1 Burial 2 4 Donation	osition ☐Cremetion 3 5 ☐ Othar <i>(Spe</i>	Ramoval from	Stata	Place of Di cemetary, o	sposi crama	tion (Nama of tory or other p	ace)		Data	20c.	Location	- City or			ind
equantially list conditions, any, leading to immadiate ausa. Entar Undarlying ausa (Disasas or Injury lat initiated avants sulling in death) Last Dua to (or es e consequence of): Dua to (or es e consequence o	23a. Pert1. Entar th shock, or haar	d N. Br e disaesa, or c t failura. List or	insfield omplications that only ona causa on a	ausad tha daa ach lina.	th. Do not	2 anter	Brinsf 22955 the mode of dy	ield :	Fune:	Road	Leo		town	Appro	ximata el Batweer	1
Dua to (or as a consequence of): Complete	disaase or condition rasulting In daath)	-inai	a. ***	Spin Dua to (or as a con	seque	enca of	Ture		•				6	W85	
any, leading to immediate aguse. Entar Underlying ause. Clisaase or Injury leat initiated avants sulting in death) Last Dua to (or es e consequence of): d			1	DITA	iton		(m	eum	OU	ug				2	dry)
art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Ware autopsy findings evailable prior to completion of cause of death? 1 Yes 2 No 1	if any, laading to imi causa. Entar Undar Causa (Disaasa or I	madiata Tying	c	0585	Cele		C	VA						3	lup)
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24a. Was an autopsy performad? 24b. Wara autopsy findings evallable prior to completion of causa of death? 1	Part II. Other signific	cant condition	s contributing to de	aath but not ras	sulting in th	a und	arlying causa g	ivan In Part	1.	23b. Dio	d tobacc	o uaa co	ontribute	to the c	ause of de	ath?
performad? evailable prior to completion of causa of daath? 1 Yas 2 No 1 Yas 2 No 5. Was casa rafarred to medical										1	Yes	2□ No	3 🗆 P	robably	40 Unk	nowr
5. Was casa rafarred to medical 26. Placa of Death (Check only one)														evailable completic	prior to in of cause	
5. Was casa rafarred to medical 26. Placa of Death (Check only one)										1	Yas	2□No		1 🗆 Yas	2□ No	
	25. Was casa rafarro	ed to medical						26. Plac	a of Deat							

Physician /Medical **Examiner**

> Physician/Medical Examiner Be Completed by Medical Certification: To

29a. Certifier (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificata be axecuted within 42 hours effect death.

To the Funeral Director: After this certificate hes been signed by the attending physician end complately filled in by the funeral director, page 2 should be deteched for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Hospital: Inpatiant 2 ER/Outpetient 3 DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 28b. Tima of Injury 28a. Data of Injury (Month, Day Year) 27. Mannar of Daath 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding Invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datamined 3 Sulcida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata) 4 - Homicida

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar

29c. Licansa number 47066 29d. Date signed (Month, Day, Year)

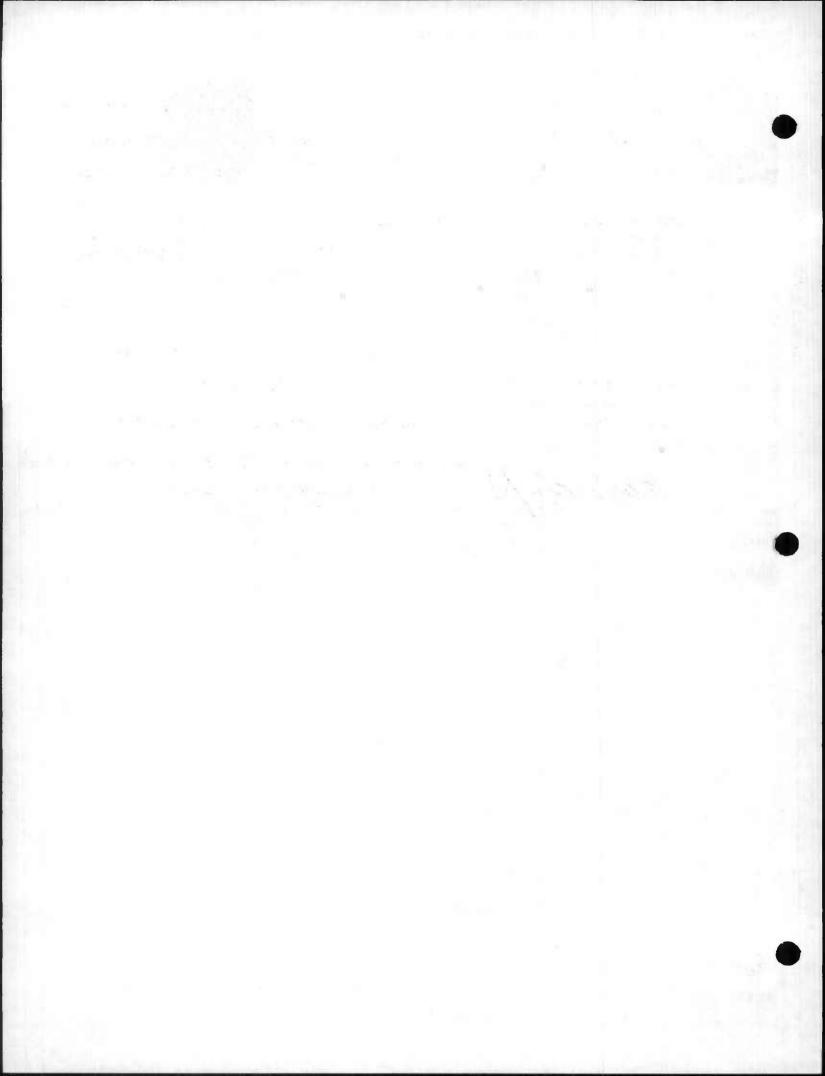
30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print)

PHILIP J. BEAN MEDICAL CTR. HOLLYWOOD, MD. 20636

AVANI D. SHAH M.D. 31. Data filed (Month, Day, Yaar)
FEB 2 0 1998

2. Ragistrar's Signatura

State Registrar



_				State of Maryla		tificate of			leg. No.	06779		
в	Physic	ian	Decedent's Neme (First, Middle, Las		10.4.000			2. Dete of Dee Month	Dey	3. Time Death		
W	/Medi	cal	GEORGE KIEF 4a. Fecility Neme (If not Institution, give		ERSTER		4b. City, Town, or L		13 199	7.71		
1	Exami	ner	41 PARK LANE	street and number)			EASTON	Ocation of Deetin	4c. County	BOT		
Н	Funeral		Social Security Number 6. Se	7. Age (In y	rs. lest birthdey)	If Under 1 Year		8. Dete of Birth				
ı	Director		218-28-4969	DM 2□F 79	Yrs.	Months Deys	Hours Min.	8. Dete of Birth (Month, Dey MAY 5,	1918	Birthpiece (State or Foreign Country) MARYLAND		
	pu .		Usuei Residence of Decedent 10e. Stete 10b. County	100	City, Town or Lo							
	fanyla shor	5								10d. Inside City Limits 1 ☐ Yes 2(X)No		
	the N	ect	MD TALBO)T	EAST	ON 10f. Zip Code			l0g. Citizen of W			
	With the second	Ö	41 PARK LANE			Tot. Zip Code	21601		US			
21215-0020	s 1 and 2 should be filed within 72 hours efter death with the Manyland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28=f show other transitic event, for Wedical Eventine must be notified at	by Funeral Director	11. Maritei Status 1 Never Merried ZOMerried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 K Wes 2 □ No If Yes, Give Yeer or Detes: WW	i	Ves Decedent of H Yes, specify Cube	dispenic Origin? (Spen, Mexican, Puerto	pecify Yes or No- Rican, etc.)		- American Indien, k, White, etc. WHITE		
5-0	72 hc	eted	15. Decedent's Edu (Specify only highest gred		16a. Deced	ent's Usuel Occup	pation during most of work	dina	18b. Kind of Bu	siness/industry		
121	Men.	Completed	Elementery/Secondery (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	d)	9				
	filed with Hygiene. ther than		12 17. Fether's Neme (First, Middle, Last)	-0-		CARPEN		CONSTRUCTION Mother's Name (First, Middle, Maiden Surname)				
Maryland	Mental Mental Mrked o	o Be	JOHN A. FOERSTER				EVA DITZ		Maioeri Surriette	1/		
ary	2 should be and Mental is marked o	To	19e. Informent's Neme/Reletionship (T)	rel Route Numbe	, City or Town,	State, Zip Code)						
	1 end 2 Health a am 27 is		DORIS C. FOERSTEE	R/ WIFE	41 PA	RK LANE,	EASTON,	MD 2160	1			
Baltimore,	Page nent o int: If I		20e. Method of Disposition 1√3(Burial 2 ☐ Cremetion 3 ☐ 6 4 ☐ Donetion 5 ☐ Other (Specify)	Removal from State		sition (Neme of netory or other plea LL CEMET		Dete 2-17-98	EASTON,	City or Town, Stete		
Salt	permit. Pag Department Important: If any Injury o		21. Signeture of Funerel Service Licens	00		Neme end Addre						
_	805 a 8		Joseph MI	Ostrowski			ELFENBEIN RISON ST.			RAL HOME, P.A.		
	Physician /Medical Examiner	ler.	23e. Part1. Enter the disease, or comp shock, or heert fellure. List only o Immediate Cause (Finel disease or condition resulting in deeth)	e. Choc	ONIC o (or es a conseq	Rena of):		ai/u		Approximate Interval Between Onset end Deeth		
Box 68760,	death certificate be executed e ettending physician end of for use es the buriel-trensit	Physician/Medical Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	. Coron	o (or es e consequence)	Grter	y Dis	ease	,	10 y rs		
	the ett hed fo	sici	Pert II. Other eignificent conditions con	ntributing to death but not i	resuiting in the ur	derlying cause giv	ren in Pert I.	23b. Did to	obacco use con	tributa to the causa of death?		
ls, P.O	es that the de igned by the be deteched	by Phy	Hypertensi	on; Chi	Onic	Obst	truch	10Y	es 2 No	3 □ Probably 4 □ Unknown		
Record	aw requir is been s 2 should	Completed	Palmonary	Disease;	Supri	aventi	ricula,	24e. Wes a perior	n autopsy med?	24b. Were autopsy findings aveileble prior to completion of cause of death?		
			Jacky Carche	e				1 🗆 Y	es 20XNo	1 Yes 2 No		
VITa	Physician: The this certificate ral director, page	o Be	25. Wes case referred to medical exeminer?	Hospitel:		3 DOA Oth	28. Piece of Deet	-				
ō	문문	-	1 ☐ Yes 2 ☐ No	28e. Dete of Injury	ER/Outpatien 28b. Time of	3□ DOA 28c. Injur Wor	4 P IAMISHID UC	me 5 Residence 128d. Describe h				
<u></u>	Attanding F or deeth. ector: After by the funer	atio.	1,⊠Neturel 5 ☐ Pending investigation	(Month, Day Year,) Injury		k? Yes 2 □ No					
Division	at or Attains effer decided in Director	Certification:	3 ☐ Suicide 8 ☐ Could not be determined	28e. Plece of Injury - A building, etc. (Spe	t home, ferm, streecify)	et, fectory, office		28f. Location (S City or Town		er or Rural Route Number,		
	To the Hospital or Attendin within 24 hours efter deeth. To the Funeral Director: Af completely filled in by the fu	edicai	29a. Certifier (Check only one) 12 Certifying Physical Exami	eician: To the best of my k nar: On the basis of exemi end menner steted.	nowledge, death inetion and/or Inv	occurred et the tin estigation, in my o	ne, dete end plece, pinion, deeth occur	and due to the c red et the time, d	ause(s) end mar ete and place, a	ner as steted. nd due to the ceuse(s)		
	Vith To t	Σ	29b. Signature and title of certifier	1		29c. Licens	e number	2	9d. Date signed	(Month, Dey, Year)		
			1 Holly	2000 N	w	D46	028		2/13/	198		
			30. Neme end eddress of person who co						(01			
			JENNIFER HOLLYWO(31. Dete filed (Month, Dey, Year)			AN'S LAN	E, EASTON	, MD 21	601			
	Sta Registr	_		32. Registrer's Sig	Davidson-Th	md.00						

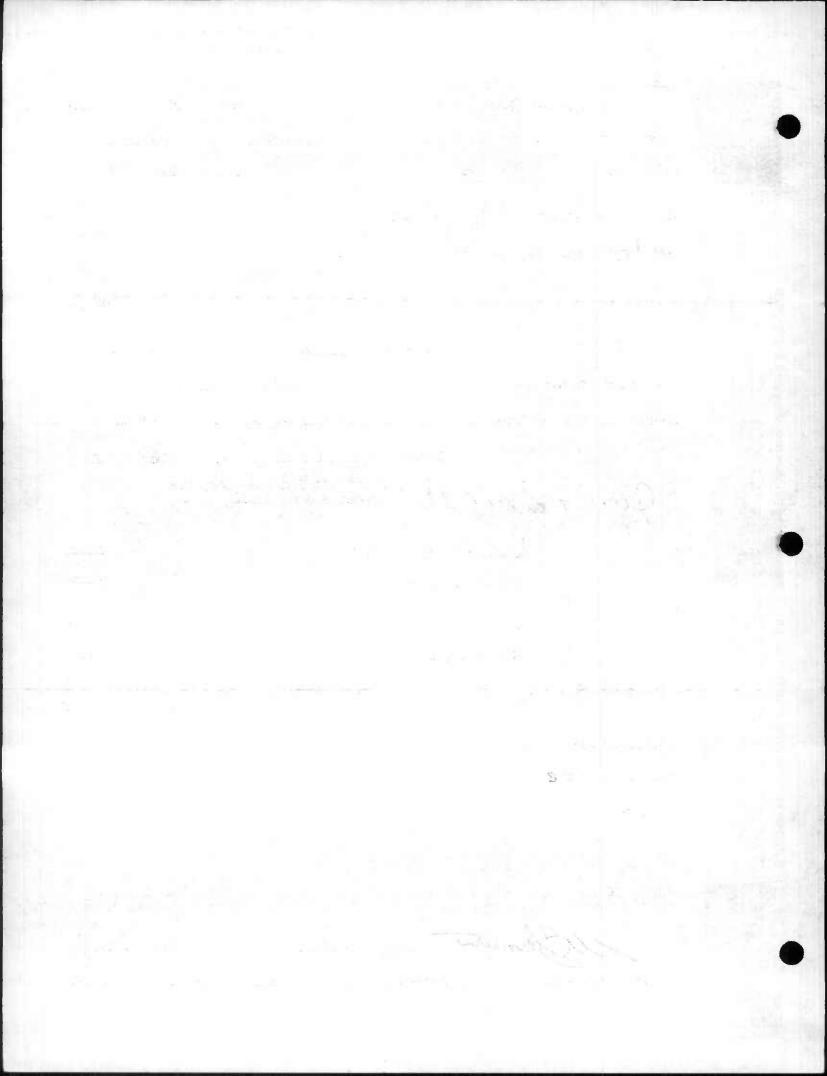
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Feb 3, 1998 Margaret Virginia Foreman 1:30 a.m. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Northampton Manor Nursing Center Frederick Frederick If Under 1 Yeer If Under 24 Hrs.
Months Deys Hours Min. 5. Social Sacurity Number Dete of Birth (Month, Day, Year)
Jan 5, 1920 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F Deys 212-12-8998 78 **Yrs** Director Usuel Residence of Decedent the Marylend 10a Stete 10b County 10c. City, Town or Location 10d. inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Frederick Director MD Frederick 1 ☐ Yes 2K No 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 5 100 Burgess Hill Way Apt. 112 "natural", or items 23s 21701 USA deeth 1 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Experiment once. Bleck, White, etc. 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Retired Cafeteria School Board 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Robert P. Thompson Mattie (McDonald) 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Charles D. Foreman-husband 100 Burgess Hill Way Apt. 112 Frederick MD 21701 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State Hillcrest Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 02/06 Cumberland MD 21. Signeture of Funaral Service Licenses 22. Name end Address of Facility
Scarpelli Funeral Home, P.A. Cumberland MD 21502 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock/or heart feilura. List only one cause on each line. Approximete intervel Between Onset end Deeth **Physician** /Medical Immediete Ceusa (Final month Cerebrovascular Accident disease or condition resulting in death) Examiner Due to (or es e consaquence of): years Examiner Hyperlipidemic physician and s the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, laading to immediate ceuse. Entar Underlying Causa (Disaase or Injury that Initieted evants resulting in deeth) Lest Dua to (or es e consequence of): Box 68760. Diabetes years Physician/Medical Due to (or es e consequence of): Hypertension years P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown signed i Records, Be Completed by 24b. Were eutopsy findings evelleble prior to completion of cause of daath? 24e. Wes en eutopsy performed? Morbid Obesity page 2 s Bilateral Amputee 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, p. 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 27. Magner of Daath 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicide 6 Could not be datermined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 4 Homicide Certifying Phyeicien: To the best of my knowledge, deeth occurred et the time, data and piece, and due to the ceuse(s) end mennar as stated.

| Certifying Phyeicien: To the best of my knowledge, deeth occurred et the time, data end piece, and due to the ceuse(s) end menner stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, data end piece, and due to the ceuse(s) end menner stated. 29a, Certifier Medicai 29b. Signetura and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Hurson D 47556 Feb. 3, 1998 30. Name and addrass of person who complated cause of death (Item 23e) (Type, Print) William H. Johnson, MD 187 Thomas Johnson Drive Suite 3 Frederick MD 21702 Trus 31. Dete filed (Month, Dey, Year) #32, Registrar's Signature State FEB 1 Registrar



State of Maryland / Department of Health and Mental Hygiene |

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 5:45a.m. James 0 Fazenbaker 02 18 1998 /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Lonaconing Egle Nursing Home 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (State or Country) Maryland 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 11XM 2□ F 70 212-24-1029 Yrs. Oct Director Usuel Residence of Decedent the Merylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 25a-f show other treumstic event, the Medical Examinar must be notified at 1 □Wes 2 □ No Director Md. Allegany Barton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Box 33 Temperance Row 21521 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: à 3 ☐ Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Peges 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "reny Injury or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Trucking Truck Driver Unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Stanley Fazenbaker Ethel Custer 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Phyllis K. Paugh P.O. Box 169, Barton, Md. 21521 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from Stete Laurel Hill Cemetery 2-21-98 Barton, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Boal Funeral Home des 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate

Approximate Approximete Interval Between Onset and Death **Physician** /Medical immediate Ceuse (Final disease or condition resulting in deeth) 2 years Examiner Due to (or es e consequence of): Examiner physician end s the bunef-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): ettending p P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t betructive Pulmenary 1 Yas 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Congestive Heart Failure Ulcer replic 1 ☐ Yes 2 ☐ No certificate **Division of Vital** 25. Wes case referred to medical To the Hospital or Attanding Physician: Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 28e. Date of fnjury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homleide Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as steted.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18,1998 D07004 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) L.R. MILES, JR., M.D. 57 JACKSON ST LONACONING MD

DHMH 16 Rav 6/95

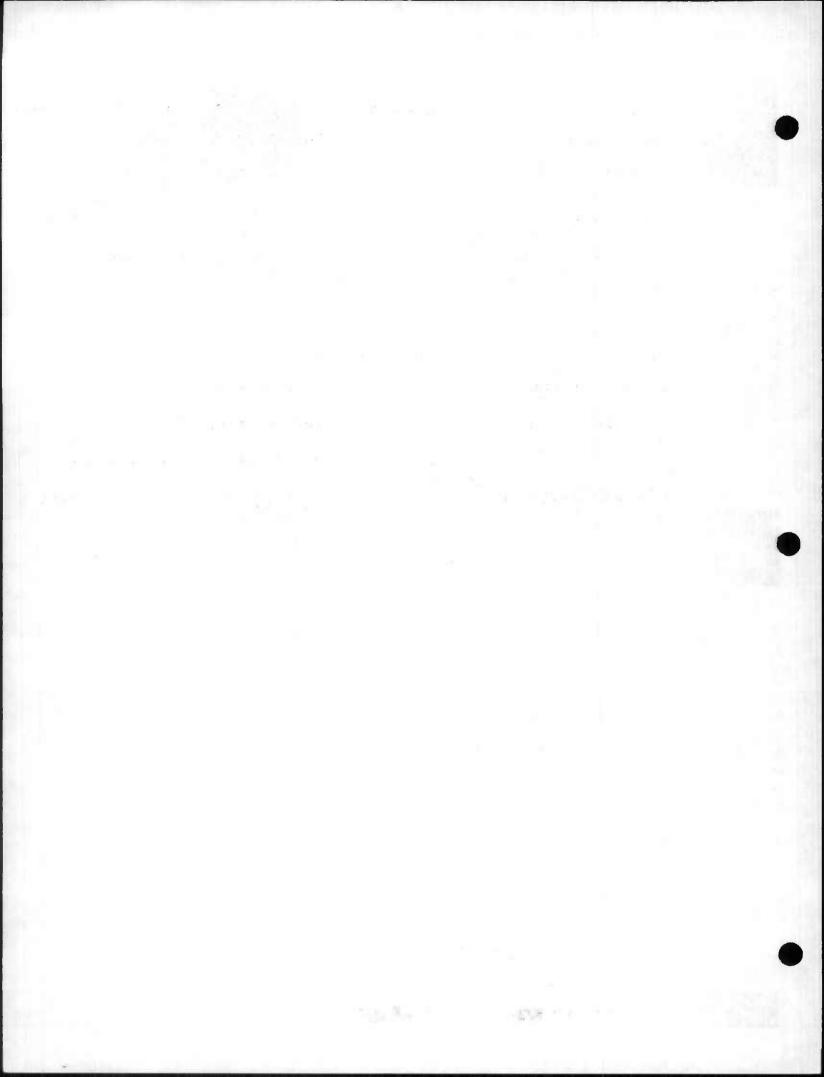
State

Registrar

31. Dete filed (Month, Day, Year)

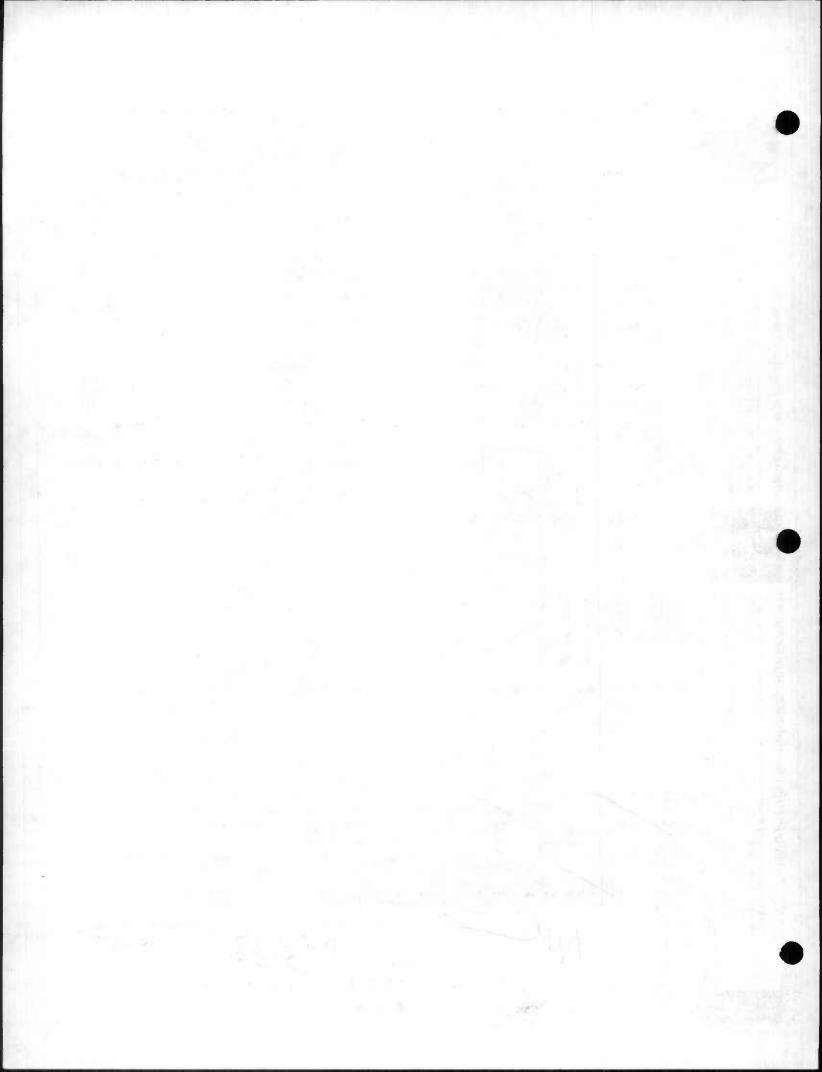
FEB 20

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 98 06782

Burldine Ada FRIEND Burldine Ada FRIEND 4a. Facility Neme (If not institution, give street and number) Garrett County Memorial Hospital 5. Social Security Number 216-28-8977 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location Month Dey Year February 18, 1998 4b. City, Town, or Location of Death 4c. County of Death 4d. County	7:30 AM
Medical Examiner Burldine Ada FRIEND February 18, 1998	(State or Foreig
Funeral Director Usual Residence of Decedent 10b. County 10b. County 10c. City, Town or Location 10b. County 10c. City, Town or Location 10b. City, Town or Location 10b. City, Town or Location 10b. City, Town or Location 10b. City, Town or Location 10b. City, Town or Location 10b. City, Town or Location 10b. City, Town or Location 10b. City, Town or Location 10b. City, Town or Location 10b. City, Town or Location 10b. City, Town or Location 10b. City, Town, or Location 10b. C	(State or Foreig
5. Social Security Number 216-28-8977 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 5. Social Security Number 216-28-8977 1	(Stete or Foreig
5. Social Security Number 216-28-8977 Usual Residence of Decedent 10e. State 5. Social Security Number 216-28-8977 1 M 2 K F 84 Yrs. 7. Age (In yrs. last birthday) 84 Yrs. 7. Age (In yrs. last birthday) 84 Yrs. 10c. City, Town or Location 10d. Ir	(Stete or Foreig
216-28-89// Mary Sept. 16, 1913 Mary Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Ir	,
Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Ir	and
10e. State 10b. County 10c. City, Town or Location 10d. In 10d	and
MD Garrett Oakland	nside City Limits
10. Street and Number	☐Yes 2☐No
THE CITY OF THE PROPERTY OF TH	
2419 Hutton Road 21550 USA 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Ves, Give Yeer or Dates: 1 Ves 2 No It Yee, Specify: 1 Ves 2 No Specify: 1 Ves 3 No Specify: 1 Ves 3 No Specify: 1 Ves 3 No Specify: 1 Ves 3 No Specify: 1 Ves 4 No Specify:	
2419 Hutton Road 21550 USA	
11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American In Black, White, etc.	ndien,
1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No I □ Yes 2 ☑ No Specify: Specify:	
	e
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 12 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Clerk Clothing Store	у
(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)	
Clerk Clothing Store	
Specify: Whit Specify: Whi	
Stephen D. Sanders Jane Shaffer	
19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code	le)
Arthur W. Friend/Husband 2419 Hutton Road, Oakland, MD 21550	
20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town 5	Stete
1 Burial 2 Cremation 3 Removal from State cemetery, creme tory or other plece)	
4 Donetion 5 Other (Specify) Oakland Cemetery 2/21/98 Oakland, Mary	land
21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Stoylort Funeral Home	
Stewart Funeral Home 32 S. Second St., oakland, MD 21550	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	roximate
	rval Between set end Death
Immediate Cause (Final	
163ditilig III deatil)	Week
Due to (or as a consequence of):	
Atherslcerosis Yo	ears
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
Gause (Disease or Injury C.	
Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as e consequence of):	
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the contribution of the contrib	
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the	cause of death
Dementia 1□Yee 3☑No 3□Probably	4 Unknow
<u>a</u>	
24a. Wes an autopsy performed? 24b. Were au evailable complete 1 Yes 2 No 1 Yes	utopsy findings e prior to
completion deeth	tion of cause
1 Yes 2 No 1 Yes	2 □ No
© 25. Was case referred to medical	2010
exeminer?	
The impatient 2 Envourpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Dother (Speciny)	
27. Mann of Death 28e. Date of Injury 28b. Time of Injury et Work? 28d. Describe how injury occurred 28d. Describe how injury oc	
9 3 Suicite 6 Could not be	
determined 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Round City or Town, State)	ite Number,
ů /	
29a. Certifier (Check only Medical Examiner: On the best of my knowledge, deeth occurred at the time, date end piece, and due to the ceuse(s) and manner as stated.	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piaca, and due to the center of the ceuse(s) end manner as stated.	cause(s)
29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, 1)	Year)
NI 227 0118165	
30 Name and address of average the appropriate and the second of the sec	
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)	
Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, Md. 21550	
State 31. Date filed (Month, Day, Year) 0 100 32. Registar's Signeture	



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Eleanor Valier FRANTZ February 9, 1998 8:00 PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 582 Hutton Road Oakland Garrett If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2♥ F Yrs Director 212-18-1556 80 Sept. 21, 1917 Maryland Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director MD 1 ☐ Yes 2 No Garrett 0akland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 582 Hutton Road 21550 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer of Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic avant 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Yaar or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No à Specify. White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/industry Elementary/Secondery (0-12) College (1-4or 5+) 1+ Housewife Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Francis 2 Patrick Baker Mary Edith 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Joseph C. Frantz/Husband 582 Hutton Road, Oakland, MD 21550 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burlai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/14/97 Oakland, MD Oakland Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Stewart Funeral Home 23a. Part1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. 32 S. Second St., Oakland, MD 21550 Approximate Interval Between Onsat and Deeth **Physician** /Medical Metasta immediate Ceusa (Final disease or condition resulting in deeth) Examiner VEGAS Due to (or es a consequence of): The lew requires that the death certificate be executed the buriel-trensit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initioted events resulting In death) Last pue Due to (or es a consequence of): Box 68760. ettending physician Physician/Medical Due to (or as a consequence of) 80 P.O. | signed by the old be deteched Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. deteched 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Records, þ pege 2 should 24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed peed hes certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Wes case referred to medicel Be 26. Place of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 X Rasidence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this To the Hospital or Attending Pr within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 X Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) end menner as stated.

Madical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the ceuse(s) end manner stated. Medical (Check only onel 29b. Signeture and the of certifier 29c. Licansa number 29d. Date signed (Month, Dey, Year) D47925 2/10/98 30. Name end address of person who completed cause of death (item 23a) (Type, Print) Dr. Charles A. Walch, MD 311 N. Fourth St., Oakland, Maryland 21550 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State Registrar **FEB 19**

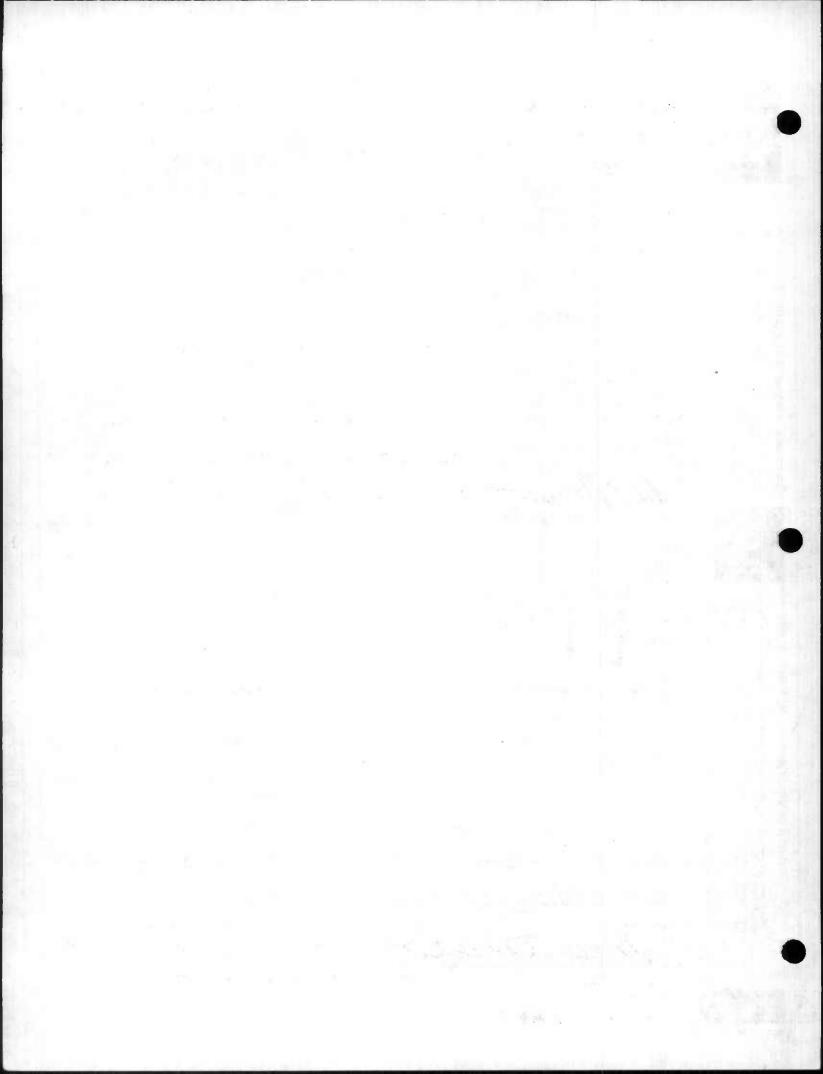
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** JOSEPH EDWARD FINK, JR. FEBRUARY 12, 1998 5:10 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 373 BURNETT ROAD OAKLAND GARRETT Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MAY 3, 1944 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1⊠M 2□ F VIRGINIA 214-42-5891 Yrs. 53 Director Usual Residence of Decedent filed within 72 hours efter deeth with the Maryland 10a State 10b. County 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at MD GARRETT 1X Yes 2 No Director OAKLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 373 BURNETT ROAD 21550 Funeral USA 12. Was Decedant Ever in U,S. Armad Forces? 1 ☐ Yes 2 X No If Yes, Give Yaar or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Black, White, etc. 1 Never Married 2 N Married 6 Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE "natural". Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 than College (1-4or 5+) permit, Peges 1 and 2 should be filled with Depertment of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic avaination. ENGINEERING ASSISTANT TELEPHONE COMPANY 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Be JOSEPH EDWARD FINK, SR. **EDNA** LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) MARY ANN FINK - WIFE 373 BURNETT ROAD OAKLAND, MARYLAND 21550 20a. Method of Disposition 20b. Piaca of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State OMEGA CREMATORY 2/17/98 4 ☐ Donation 5 ☐ Other (Specify) MORGANTOWN, WV 21. Signat 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disabse, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseasa or condition resulting In death) **Examiner** Due to (or as a consequ Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last ettending physician end for use es the burial-tren Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 ☐ Yas 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical 28. Plece of Death (Check only one) 10 1 Yes 2 No Other: 4 Nursing Homa 5 Hesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerel Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 Natural death. 1 ∏ Yas 2 ∏ No rilled in by the f 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) efter Direc 4 Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner stated. edicai 29a, Certifier (Check only one) \$ 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) FEBRUARY 13, 1998 H26154 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0, P.DANIEL MILLER, D.O. 69 WOLF ACRES DRIVE OAKLAND, MD 21550 31. Data filed (Month, Day, Year) --32. Registrar's Signature State

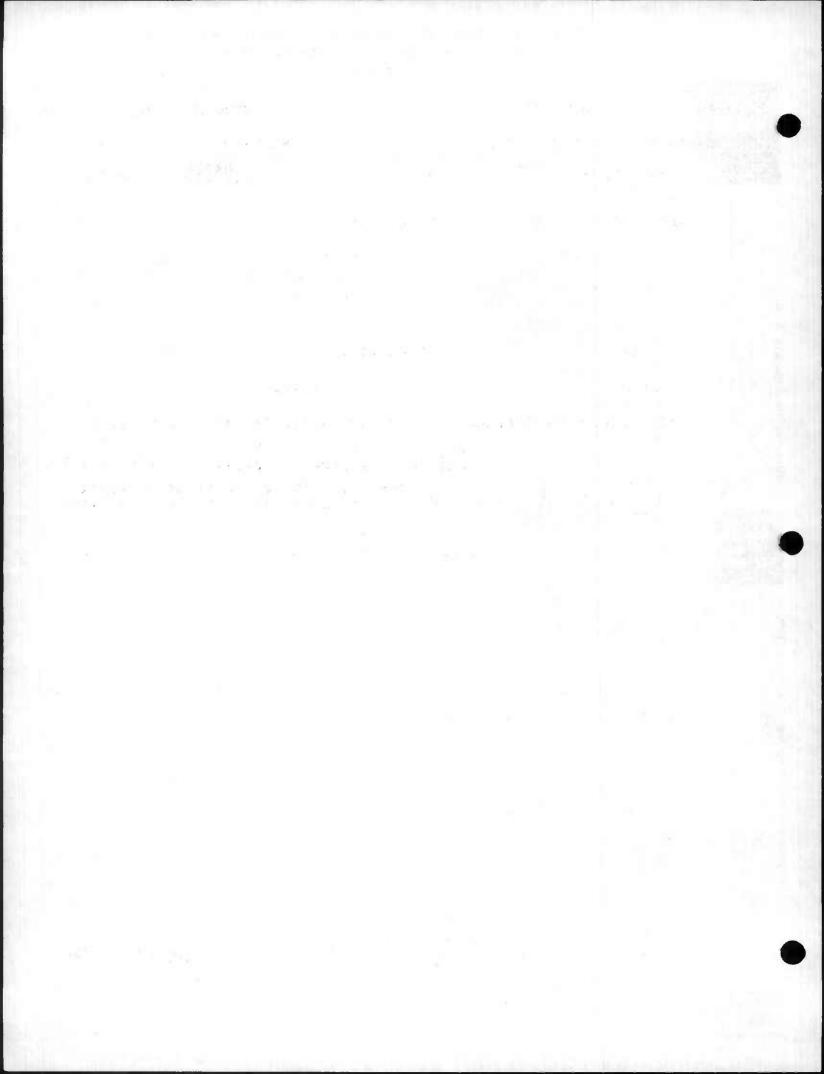
DHMH 16 Rev 6/95

Registrar

EFR 1 3 1998



	_	Decedant's Nama (First, Middla, La	rst)	Ce			2. Data of Dea			3. Tima of Death
ician dical niner		AGNES L. MC GE				4b. City, Town, or L		RY 18 1		7:52 AM
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		Sual Rasidance of Dacedant Oa. Stata 10b. County		10c. City, Town or I	Location				100	3. Inside City Limite
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ner	in di re	3a. Part1	a. As	ma daath. Do not a a.	ntar tha moda of dylr	MONAL H	or raspiratory arr	VALE, est,	A	1502 Approximate Interval Batween Onsat and Death
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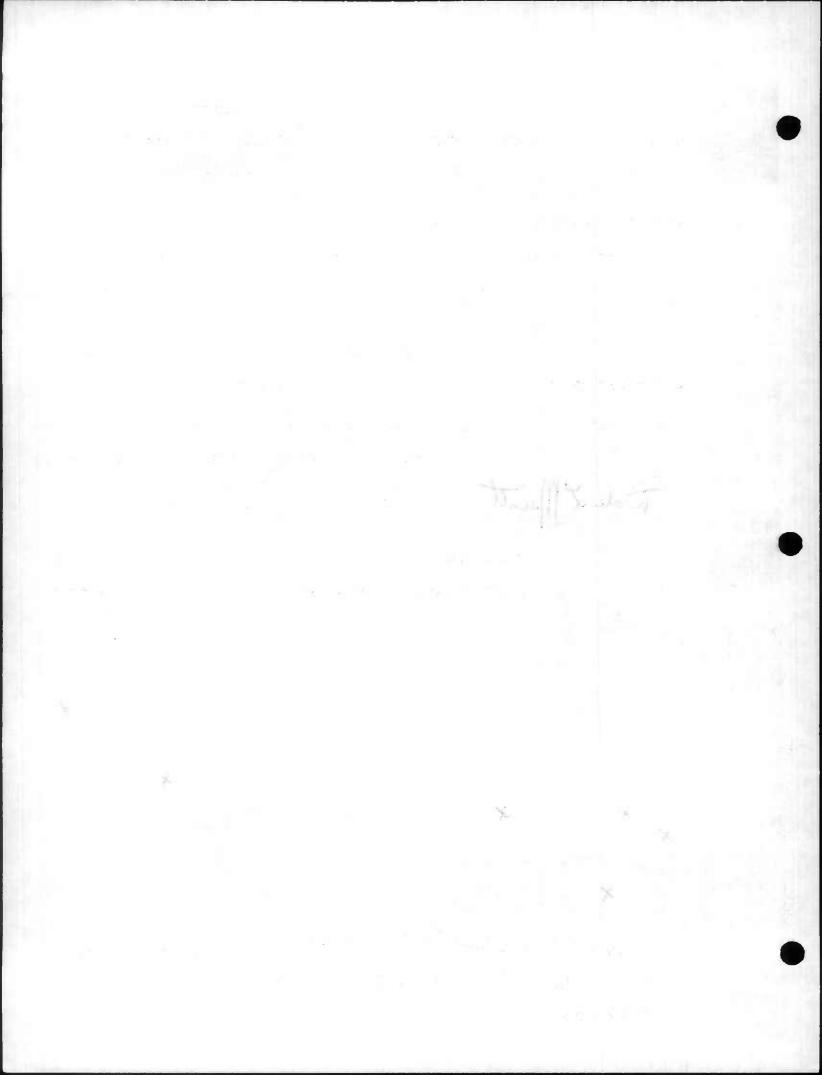


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** SHIRLEY ANN GRAY **FEBRUARY 19 1998** 12:15 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ALLEGANY if Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) MAY 24 1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 KANSAS **Funeral** Months Days 1□M 2√F 498-48-1004 54 Yrs Director Usual Residence of Decedent death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits reast be notified at Director 1 ☐ Yes 2€ No MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11829 VALLEY ROAD N.E. 21502 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Biack, White, etc. 7 is marked other than "natural", or items traumatic event, the Medical Examiner in filed within 72 hours after I ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 21215-0020 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 HOUSE KEEPER HOUSE KEEPER Baltimore, Maryland 17. Father's Name (First, Middle, Last) . Peges 1 end 2 should be filk ment of Health end Mentel Hy lant: If item 27 is marked oth jury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT MARTINDALE IRENE BRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) KIM A. BAKER DAUGHTER 11829 VALLEY ROAD N.E. CUMBERLAND MARYLAND 21502 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 remation 3 ☐ Removal from State thent CUMBERLAND CREMATORY FEB 20 1998 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Depart Import any Inj ature of Funerei Servica Lica 22. Name and Address of Facilit MERRITT-ADAMS FÜNERAL HOME X 404 DECATUR STREET CUMBERLAND MARYLAND Part 1. Enter the diseese, or complibations that caused the shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SEVERE COPD 5 YEARS Examiner Due to (or as a consequenca of): Examiner SEVERE DILATED CARDIOMTOPATHY 5 YEARS Attending Physician: The lew requires that the death certificate be executed the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest end Due to (or as a consequence of): SHIRLEY GRAY 498-48-1004 Division of Vital Records, P.O. Box 68760, physicien Physician/Medical Due to (or es e consequence of) USB BSU Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? the s been signed by the should be detact 1 Tyes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? Completed hes page 2 certificate 1 Yes 1 ☐ Yes 2 ☐ No director 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1. Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident or Attend efter death Director: 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide Hospital o 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a, Certifier To the Vithin 2 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) D 34846 8 FEBRUARY 20, 1998 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 21502 phs ROBERT ORLINO M.D., 902 SETON DRIVE, CUMBERLAND, MD 31. Date filed (Month, Day, Year) 32. Fugistrar's Signature State EB 2 3 1998 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Physician FEBRUARY 17 1998 Richard Wineow George 11:40 AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Sacred Heart Hospital Allegany Cumberland If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. 5. Sociel Security Number Birthplece (State or Foreign Country)
 MD 7. Age (In yrs. lest birthday) **Funeral** Months Deys 100 M 2□ F 705-10-6675 85 Yrs Director Usuel Residence of Decedent death with the Maryland 10a State 10b. Counts 10c. City, Town or Location 28a-f show 10d. Inside City Limits Director 1 ¥ Yes 2 No Cumberland Allegany 10f. Zip Code 10e. Street end Number 10g, Citizen of Whet Country? ò items 23a 903 Braddock Road 21502 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mantal Hygiena.
Int: If item 27 Is marked other than "natural", or item
Int or other traumatic event, the Medical Examiner Yes 2X No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: þ Specify 3₺ Widowed 4 Divorcad white Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Pipefitter/Welder Railroad 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Raymond W. George Mary Ella (Swauger) 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lois Branson-daughter 1184 Greens Farm Road Amelia OH 45102 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑Burlal 2 ☐ Cremation 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donetlon 5 ☐ Other (Specify) Sunset Memorial Park 02/20 Cumberland MD 21 Signature of Funeral Service Licenses 22. Name and Address of Fecility
Scarpelli Funeral Home, P.A. mes 4 Cumberland MD 21502 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete fnterval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest physician s the burial Physician/Medicai Due to (or es e consequence of): 8 USA s certificate has been signed by the a director, page 2 should be detached it Pert fl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No M Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28h. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1X Naturel 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, Records, Division of Vital Hospital or Attending Physician: To the Hospital or Attendir within 24 hours aftar death. To the Funeral Director: Af illed in by the completely

Baltimore, Maryland 21215-0020

State Registrar

Medicai

29a, Certifier

(Check only one)

29b. Signature end title of cartifier

31. Dete filed (Month, Day, Year)

29c. License number

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated.

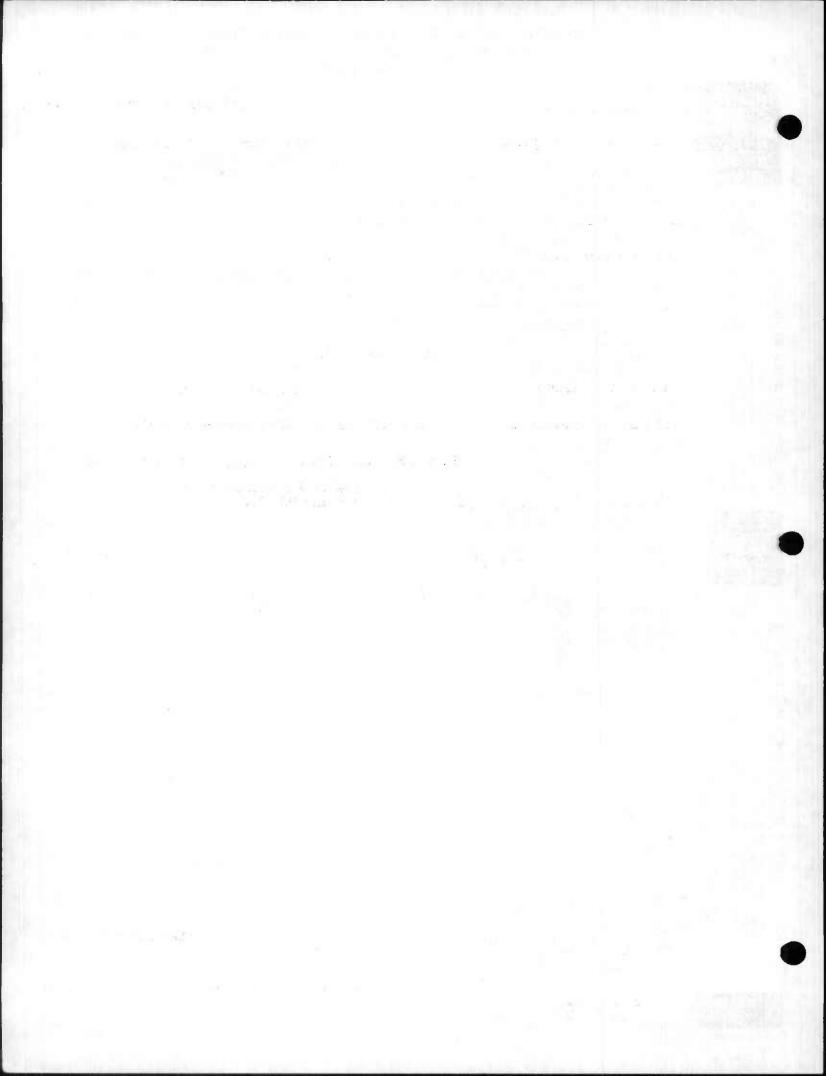
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29d. Dete signed (Month, Dey, Yeer) FEBRUARY 20, 1998

who completed cause of deeth (Item 23e) (Type, Print)

M.D.

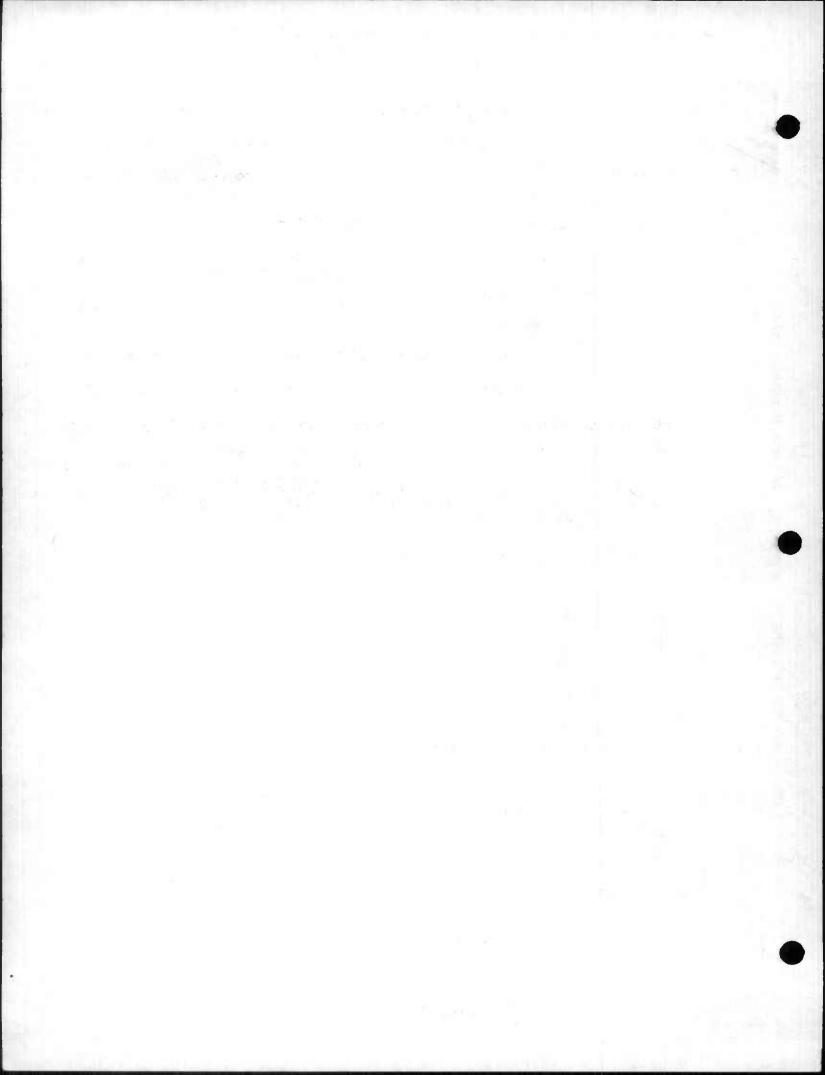
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State of Maryland / Department of Health and Mental Hygiene

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Division To the Hospital or Attend within 24 hours effer deat To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Ex	caminer: On the basis end menner	s of exemine	tion end/or l	Investigation	In my o	plnion, deeth o	ccurred et the	time, dete	end placa,	end due to	tha cause(s)
To the within 2 To the I	₩ E	29b. Signeture end title of certifier	011011101	010100.	_	290	Licens	a number		294	. Data signe	ed (Month I	Day Year)
or My co		7. /	tolul.		70.0	2.30	.0	2226	-7		1/12/	00	
12		fam!	-//		100		1)	3335	1	2	-119	7 6	
		30. Neme and address of person w	no completed cause of	of deeth (Item	n 23e) (Type	e, Print)			_		,	-1	n his
		Lee Jonat	han mus	her v	m J	530	W	uscens,	in the	e (hery !	Char	~ (1)
C	tate	31. Date filed (Month, Day, Yaar)	32 Regi	istrar's Signa	iture								
Pegis		FEB 17 19	9 Julia	Davidon	1 7 Day	.00							



			State of Maryland	/ Department of Certificate of	Health and M	lental Hyg		06789
		1. Decedant's Nama (First, Middle, Last		1	E.S	2. Data of Deat		3. Time of Death
Physic /Medi		IDA R.	GOLDSTEL	\sim		Month 2	14 98	3 7:27AM
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	cation of Death	4c. County of Dea	th
		Holy Cross Ho	spital		Silver S	pring	Montgo	mery
Funeral Director		5. Sociel Security Number 6. Se 10 4 10 6 168 1D Usuel Rasidance of Dacedent	7. Aga (In yrs. last	t birthday) If Undar 1 Yaar Months Days		8. Data of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foraign puntry) W YORLL
the Maryland 28a-f show notified at	7	10a, State 10b, County		own or Location				10d. Insida City Limits
28a-f	Director	MD Montgo	omery Silv	ver Spring				1 Yas 2 No XX
£ 8 8		2201 Colston D		10f. Zip Coda	20910	10	og. Citizan of What Co	ountry?
ns 23	era	11. Marital Stetus	12. Wes Decedant Evar in U,S.	13 Was Decodert of		oity Voe or No	USA 14. Race - Ame	grican Indian
If a creation of the country of the	by Funeral	1 □ Never Married 2 □ Married Never Married 2 □ Married	Armed Forces? 1 Yes 2 No If Yes, Give Yaar or Datas:	13. Was Decedant of If Yes, specify Cut		Rican, atc.)	Black, Whi	
2 ho	be	15. Decedent's Edu	cation 1	6a. Decedent's Usuel Occu	pation		16b. Kind of Businass	
within 7	lg.	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Giva kind of work dona life, DO NOT usa ratire	i dunng most of worki 9d)	ng		
Hilled will Hygien of ther the	Completed	10000000000000000000000000000000000000	2	Secretary		E	mploymen	t Agency
Most yield of ALL 10-0000 2 should be filled within 72 hours at h and Mental Hygense. I is merked other than "nahural", or treumentic event, the Medical Exami	To Be	17. Father's Name (First, Middle, Last) Louis Rackoff			18. Mothar's Nama		faiden Sumema)	
death certificate be executed x death certificate be executed x death certificate be executed x death certificate be executed x death certificate and death certificate and death certificate as the burial-transit are death certificate.	Physician/Medical Examiner	19a. Informant's Name/Retationship (T. LOTTAINE Van K. 20a. Method of Disposition 1 Burial 2 Cremation 3 P. Donation 5 Other Specify) 21. Signature of Funeral Station License 23a. Part 1. Enter the disease, or complishock, or heart failure. List only or language of sendition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated avants rasulting in death) Last Part II. Other significant conditions con	cations that caused the death. It cause on each line. RESPIRATORY Due to (or as Due to (or as Due to (or es death).	IVES PER DO NOT A COMMENT OF STREET	rematory ess of Facility arson Fu Washing tardacco	Wheat Deta 2/15 neral on St or respiratory arra	on, Mary Oc. Location - City or Alexandr Home Falls Ch	land 20902 Town, Stata ia, Virgini 22046
law requires that the delas been signed by the a	by Phy	DIABRES MELL					./	robably 4 Unknown
inper s	Completed					24e. Was ar perform	ied?	Wara autopsy findings availabla prior to complation of cause of death?
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ician: The	Be	25. Wes casa raferred to medical axaminer?	lospital:	100	26. Place of Deeth			
To the Hospital or Attending Physician: within 24 hours after death. To the Fureral Director: After this certifica completely filled in by the funeral director,	ation: To	1 Yas 2 No Carte 1 Yas	1 UPInpatiant 2 □ ER	b. Tima of lnjury 28c. Inju			nca 6 □Other (Spe w injury occurred	cify)
tal or Atters after de al Directo ed in by th	Certification:	3 Suicida 6 Could not be determined	28a. Piaca of Injury - At homa building, atc. (Specify)	, farm, straat, factory, office	2	28f. Location (Str City or Town	aat and Number or R , State)	ural Routa Number,
the Hospi in 24 hour the Funer pletely fill	edicai	(Check only 2 Medical Examination)	sician: To the best of my knowled ner: On the basis of exemination and mannar statad.	and/or invastigation, in my	opinion, daath occurra	ad at the time, de	te and place, end du	to tha cause(s)
To To To To To	Σ	29b. Signature and title of gartifier			se number	29	d. Deta signed (Mon	
12		30 Name and address of a second	moleted squae of death floor an		4886		2 14	98
		MANUE H. SIG M.	D. 10801 Locken	Dave	Saves S	prints V	Carrian	
Sta Registi		31. Data filad (Month, Day, Year) FEB 17 199	32. Registrar's Signatura	an Backette				

funeral director, page 5 should be detached for

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attending physician and con ntal Hygiene prior to burial,

this certificate has been signed by the atterwith the State Dept. of Health and Mental

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OR ATTENDING PHYSICIAN:

After the death v

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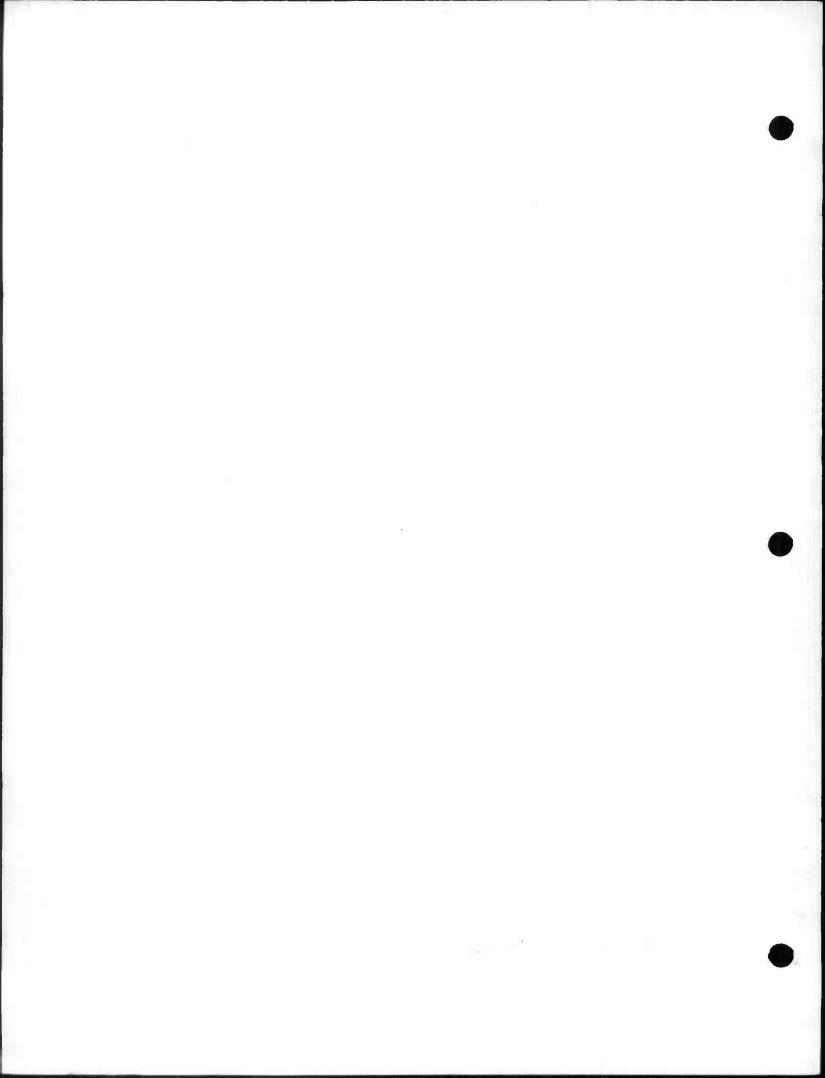
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Selma E. Good A February 3:28 998 A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. 1 M 2 FF HOURS 578-20-3746 YRS. 88 March 25 1909 Virginia 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR Sharon Nursing Home Sandy Spring Montgomery RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Potomac 1 YES 2XXNO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9412 Copenhaver Drive 20854 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES TYPE YOU IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married
3 Widowed 4 Divorced ВУ Specify: White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 12 Executive Secretary 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Malden Surname) H Emory Hoge Miller BE Matilda Eliza Vaughan notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Fural Route Number, City or Town, State, Zip Code) 9 Charles B. Good, Jr. 9412 Copenhaver Drive, Potomac, Maryland 20854 pe 20e. METHOD OF DISPOSITION
1 N Buriel 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) February 19, Gate of Heaven Cemetery 29c. LOCATION - City or Town, State must 1998 Silver Spring, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LIGHTSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery M00803 Home/Rockville, Inc. 300 West Montgome Avenue, Rockville, Maryland 20850-2805 medicai 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory erreat, Approximate shock, or heart failure. List only one cause on sech line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition_ SEPTIC SHOCK 24 Hours reaulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): GANGRENE 24 Hours LEFT CERTIFICATION Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events OUE TO (OR AS A CONSEQUENCE OF): or other DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST injury, PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY shows any 1 TYES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) Item HOSPITAL: OTHER: 1 TES 2 TONO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 - Residence 6 - Other (Specify) marked, or 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 5 Pending Investigation 1 Natural BY 1 YES 2 NO 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FUNERAL DIRECTOR: Aft within 72 hours after deat TANT: If item 28 is n 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be determined 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE be filed within 72 hours at IMPORTANT: If item 2 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day Year) 33700 16 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) IED OVERLOOK DRIVE M

32 REGISTRAR'S SIGNATURE

Junia Davidson Rondoll

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020	ng physician.	burial-transit
E, MARYLAND 21215-0020	ay be retained by the hospital or attending	page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
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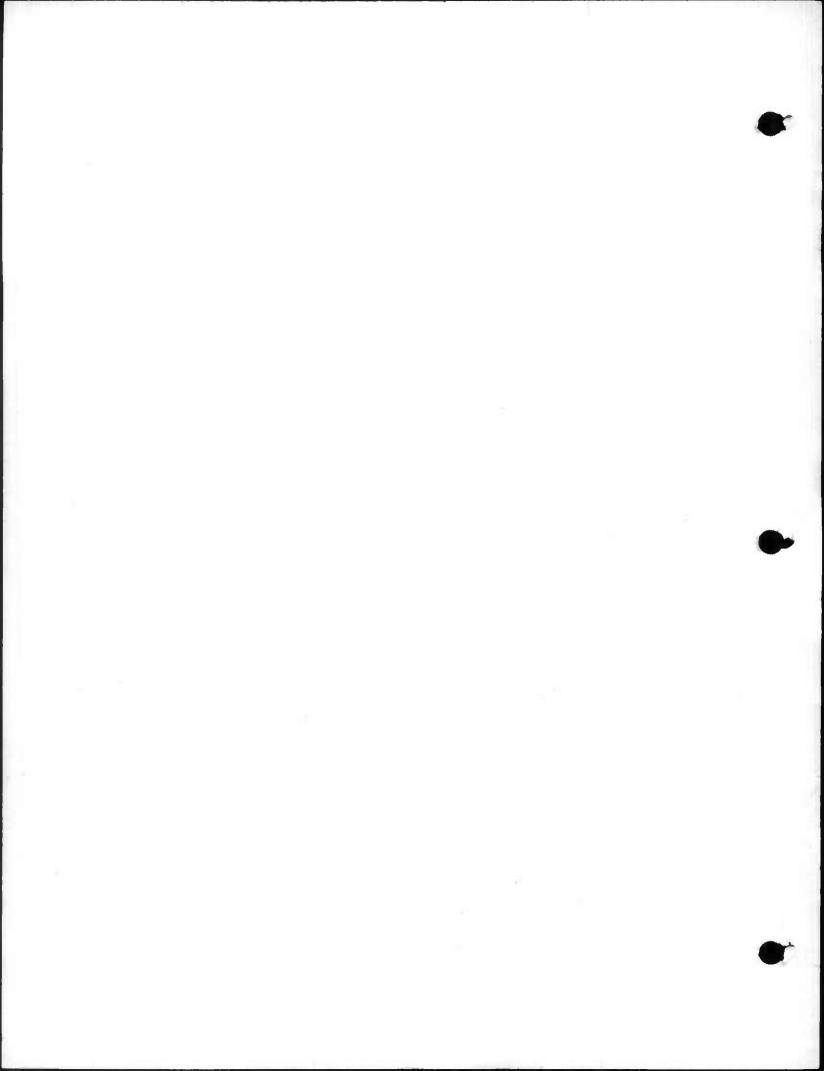
DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND	hours after death. Page 6 may be retained by the hosp	ed in by the funeral director, page 5 should be detached or removal.	medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

FOR STATE REGISTRAR	STATE OF			TMENT OF H	
DECEDENT'S HAME (First, Middle, Last)					
	Gilbert	James	Gord	lon	
SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	lest birthday)	IF UNDER 1 YEAR	IF UNDE

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S HAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY	VEAR	3. TIME OF DEATH			
		<u>ilbert Jan</u>	nes Gordo	าก		February	Ĩ8, 1	998	5:50 P M			
		-		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH	PLACE (State or Foreign			
	579-07-4955 1 9a. FACILITY HAME (if not institution, give stree	1 Ø M 2 □ F 7	/ YAS.				1920		ryland			
œ					OR LOCATION OF D	EATH		NTY OF DE				
5	College View Center	31.		Frede	rick		Fred	deric	K			
DIRECTOR	10e. STATE 10b. COUNTY			TOWN OR LOCA	TION				10d. IHSIDE CITY LIMITS?			
٥		erick	Fre	derick					1 X YES 2 NO			
FUNERAL	700 Toll House			101	ZIP CODE				HAT COUNTRY?			
NE.	700 Toll House Ave	ONUE 2. WAS DECEDENT EVER I	NIIS ADMED	12 300 000	21701	NIC ORIGIN? (Specify Y			states			
	1 Never Merried 2 Merried	FORCES? 1 YES	2 HO	If yes, sp	ecify Cuben, Mexics 2 ☑ HO Specifi	en, Puerto Rican, etc.)	ee or No-	Black	— Americen Indian, , White, etc.			
ВУ	3 💢 Widowed 4 🗌 Divorced		WW II	1 123	Z A NO Specii	у.		Specif	White			
围	15. DECEDENT'S EDUCAT (Specify only highest grade con	IOH mpleted)	16a. DECEDENT'S U	rk done durina ma	OH st of working	16b. KIHD OF B	USIHESS/IHD	USTRY				
٦	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me. Do NOT use					CN				
COMPLETED	17. FATHER'S HAME (First, Middle, Last)		Quality Ass	surance S		Departr		↑ Na	vy			
Ö	Walter Gordon				Eva R		n Sumeme)					
BE C		daughter)	19b. MAILING A	DORESS (Street a		Route Number, City or To	wn, State, Zip	Code)				
2	Patricia G. Holling	sworth				ysburg, P						
	20e. METHOD OF DISPOSITION 1 Durial 2 Cremation 3 Remova	from State	PLACE AND DATE OF	DISPOSITIOH (No	me of		OCATION 0	-	vn, Stata			
	4 Donation 5 Other (Specify)	C	netery, crematory or other hesapeake			2-19 Bel	tsvil	le, M	Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. HAME AND ADORESS OF FACILITY Rapp Funeral Services, P. A.											
	Ellen W.	Kapp		933 6	iist Aver	nue. Silve	r Spr	ina.	MD 20910			
	23. PART I. Enter the diseases, or com ahock, or heert fellure. Lis	iplications that cause it only one ceuse on e	d the death. Do no ech line.	t enter the mo	de of dying, suc	th as cardiac or rea	piratory arr	eat,	Approximate Interval Between			
	IMMEDIATE CAUSE (Finel disease or condition	Sea							Onset and Death			
	resulting in death)	JEHSIS	COHSEQUENCE OF:						WEEK.			
-		00E 10 (0N AS A	CONSEQUENCE OF J.						j			
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	OUE TO (OR AS A	CONSEQUENCE OF):									
S	cause. Enter UNDERLYING CAUSE (Disease or Injury											
E	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):									
CER	d											
CAL	PART II. Other algnificant conditions of	ontributing to deeth b	out not reaulting in	the underlying	ceuse given in	Part I. 24s. WAS A	N AUTOPSY		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
20						1 YES	. 4		COMPLETION OF CAUSE OF DEATH?			
ME								- 1	1 - YES 2 X NO			
PHYSICIAN: MEDI	DID TOBACCO USE CONTRIB 25, WAS CASE REFERRED TO MEDICAL				UNCERTAI	N 🗆						
Sign	EXAMIHER?	IOSPITAL:		THER:								
¥	27. MANNER OF DEATH	□ Inpatient 2 □ ER/Outp 28a. DATE OF IHJURY	28b. TIME	OF 26c, IHJ		6 ☐ Other (Specify) 26d, DESCRIBE HOW	INJURY OCC	LIBED				
ВУ Р	1 Hetural 5 Pending Investigation	(Month, Day, Year)	IHJUF	RY WO	RK? 'ES 2 NO							
	3 Suicide 6 Could not be	28e. PLACE OF IHJURY building, etc. (Spec	— At home, ferm, stre	et, fectory, office		26t. LOCATION (Street	end Number	or Rural Ro	oute Number,			
	4 Homicide determined	John Maria (Special				City or Town, Steh	")					
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSICIAL	H: To the best of my know	ledge, death occurred	at the time, date	and place, end due	to the ceuse(a) end m	enner ea atate	od.				
ŏ.	one) 2 MEDICAL EXAMINER: C	On the basis of examination	n end/or investigation,	in my opinion, d	eath occured at the	time, date end place, e	nd due to the	cause(e)	end menner ee stated.			
w I	296 GIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE HUN	WBER			Month, Day, Year)			
TO B	IM Warun	- W	7		D476	11	1 2	1/18	198			
	30. NAME AND ADDRESS OF PERSON WHO CO		ATH (ITEM 27) (Type, P	ANTEY	A.10 th	2001 E -	02: ::	Mar	J 21702			
	31. DATE FILED (Month, Day, Year)	32. BEGISTRAR'S SIGN		TUNET	TVIC	and Line	JAMER	_ PU	J 2170 C			
	FFR 1 9 1999	Lulia Dainda	A Produces						1			





State of Maryland / Department of Health and Mental Hygiene

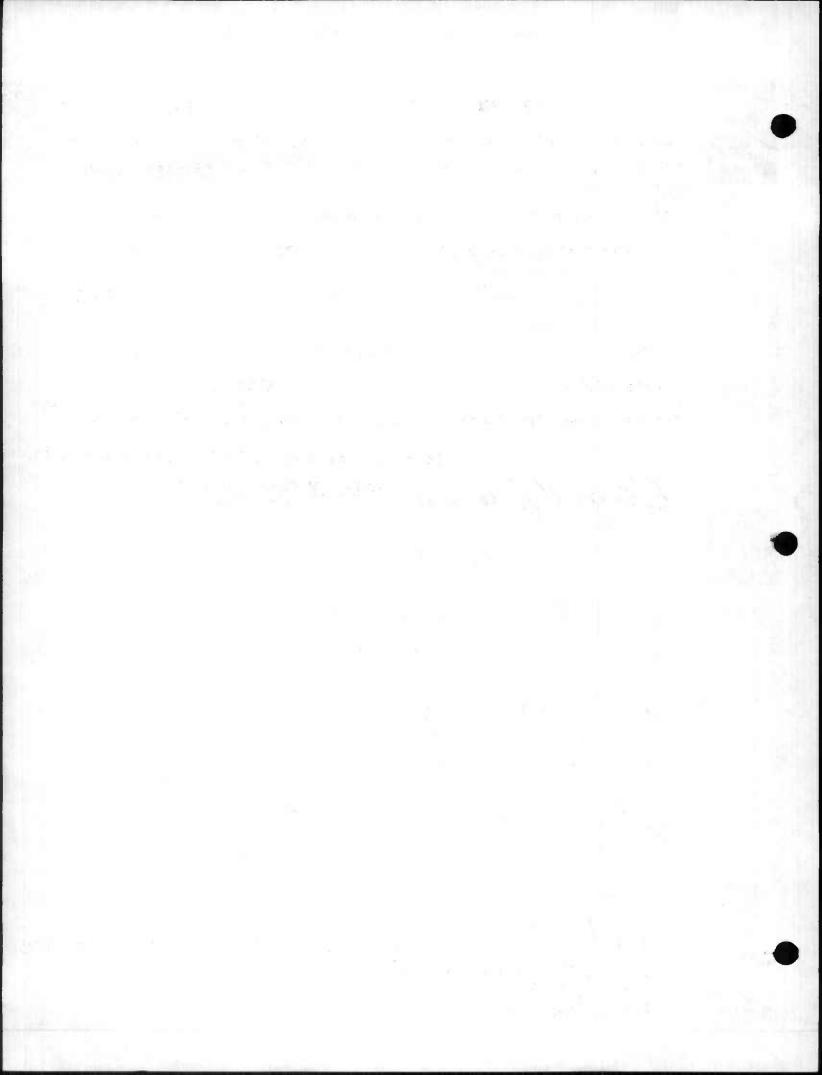
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month CLAUDIE MAE GREEN 16, FEB 1998 5:35 A /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Shady Grove Rehab. Center Rockville MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (Nonth, Dey, Year) | Georgia 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 1□M 3€7 F 578-07-5942 85 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Director Montgomery Gaithersburg 1 Yes 2 No 10e. Street end Number 10f, Zip Code 10g. Citizen of What Country? 14530 Turkey Foot Road 20878 U.S.A. Herrs 23a Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: if New 27 is marked other than "natural", or New any Injury or other traumatic event, the Modical Evantines once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8th Housewife None 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John Hicks Eliza? 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2 0 8 7 8 19e. Informant's Name/Relationship (Type, Print) 14530 Turkey Foot Rd., Gaithersburg, MD Arthur Green, Jr. (Son) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/19/98 Gaithersburg, Pleasant View Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
SNOWDEN FUNERAL HOME,
ROCKVILLE, MD 20850 21. Signatura of Funeral Service License P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Asyste Le

Due to (or es e consequenca of): /Medicai Immediete Cause (Final disease or condition resulting in death) Examiner attack physician and s the burial-transit The law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): DUSCAL Box 68760, Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? attack X 1 Yes 2 No 3 Probably 4 Unknown Heurt Records, Be Completed by Hepatic Abcess 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was en eutopsy performed? HXPO Albumi NEMI'S 1 Yes 2 No 1 ☐ Yes 2 ☑ No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificatible filled in by the funeral director; it 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Sulcide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homloide 24 hours Certifying Phyaician: To the best of my knowledge, death occurred et the time, dete and placa, and due to the cause(s) end manner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated. To the Hospi within 24 hou To the Funer completaly fil Medical 29e. Certifier (Check only one) 29b. Signature endrtitle of certifier 29c. License number Nan 39372 MD 0 30. Name and eddress of persen who completed cause of death (fum 23a) (Typ). Print) V L J T

S (L v L J) 1 7 2 2 9 0 1

31. Determined (Month, Day Vast) Registrar's Signature State FEB 19 1998 Levidson-Randelle Registrar



State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 1. Dacedent's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death 15,1998 **Physician** Ann Eleanor Greene Feb. 10:30am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Spring 12413 Littleton St. Silver Montgomery | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | SIII | 5. Social Security Number 7. Aga (In yrs. last birthday)
58 **Funeral** 9. Birthplaca (Stata or Foreign 1□M 20XF 579-50-5743 Yrs. Director Washington, Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumetic event, the Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8 20906 U.S.A. 12413 Littleton St. Items 23a Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after lent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 3€No Specify: þ Specifilhite 3 ☐ Widowed 4 ☐ Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Miriam Lipschitz marked Milton Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Hear Department if flem 27 is Important: if flem 27 is Seymour Greene/Husband 12413 Littleton St. Silver Spring, MD 20906 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1X Burial 2 □ Cremation 3 □ Permoval from State 4 □ Donation 5 □ Other (Spaying) Judean Mem. Gdns. 2/16/98 Olney, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Tves-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, 22201 VA 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock or heart failure. List only one cause on each line. **Physician** /Medical mmediate Cause Final Examiner resulting In death) Examiner the Hospital or Attending Physician: The lew requires that the death certificate be executed iding physician end ise es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initieted events resulting in deeth) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Date of Injury (Month, Dev Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury et Work? Affer 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No eral Director: A filled in by the f 2 Accident 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) To the Hospital or Att within 24 hours after d To the Funeral Direct 4 | Homicide 117 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

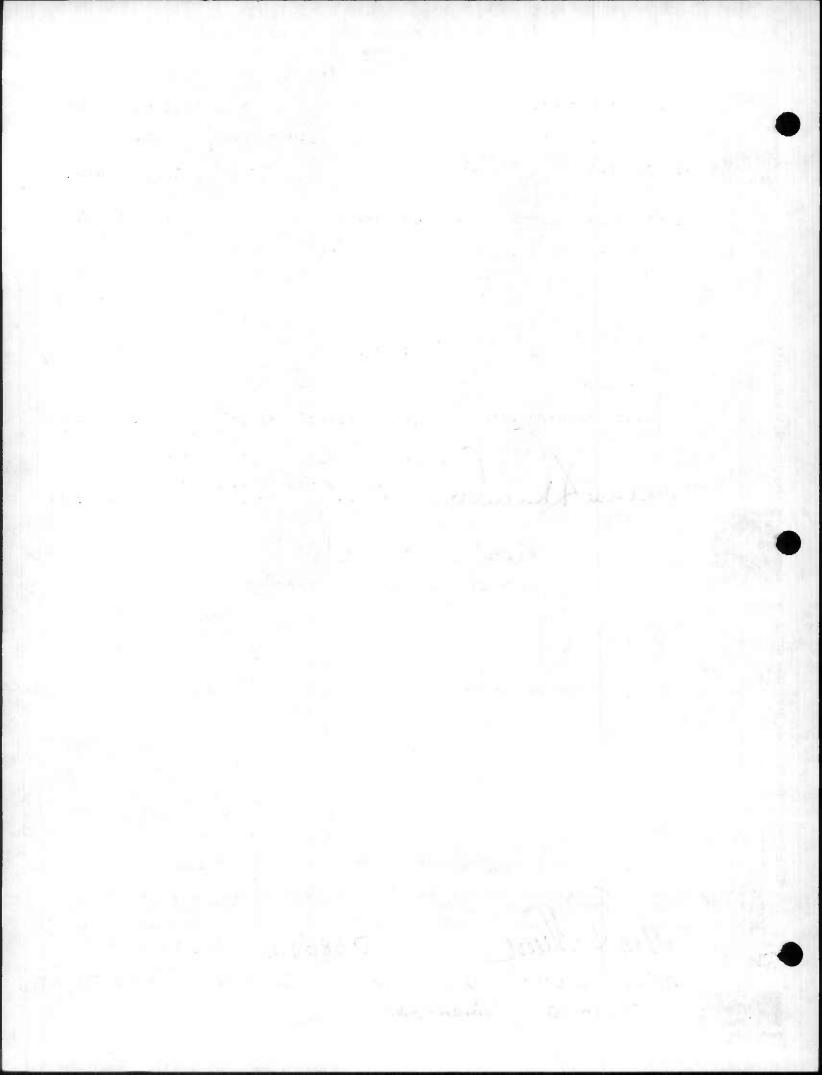
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifie er: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertities 29c. License number 29d. Date signed (Month, Day, Year) 2/15/98 ted ceuse of death (Item 23a) (Type, Print) FernWOOD Dr # 405 10215

State Registrar

31. Data filed (Month

aar) 32 Registrar's Signature Signature Fundal

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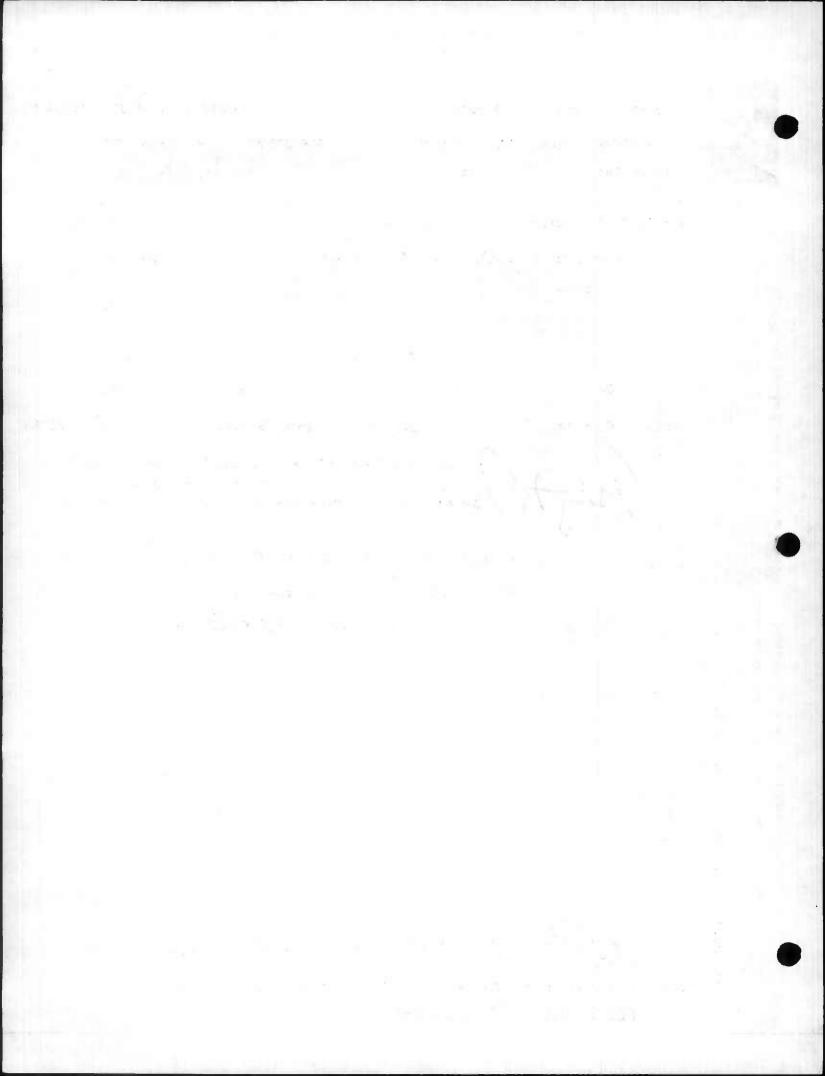


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month 3. Time of Death **Physician JOHN FEBRUARY** 13, 1998 12:50 PM **LEWIN** CRIFFIN /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner "E" 19509 GUNNERS BRANCH ROAD, APT. GERMANTOWN MONTGOMERY If Under 1 Year If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Country) Ohio 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, **Funeral** 1₽M 2□F Days Yrs. 279-20-0283 74 Feb Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🖾 No Maryland Montgomery Germantown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 19509 Gunners Branch Road, Apt. # E 20876 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indian, Biack, White, etc. e filed within 72 hours after of Hygiene.
Other than "natural", or item 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 🕅 Married natural, or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondery (0-12) College (1-4or 5+) 12 O.R. Tech Hospital permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If item 27 is marked other any Injury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Griffin 20 Oscar Perry Leona 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19509 Gunners Branch Rd., #E, Germantown, MD. 20876 Margaret Griffin/Wife 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Buriai 2 ☑ Cremation 3 ☐ Removal from 6 5 Other (Specify) 4 Donation Arlington National Cem. 2/23/98 Arlington, Virginia 22. Name and Address of Fecility DeVol Funeral Home ral Service Licens 110 East Deer Park Dr., Gaith caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Pert1. Enter the disease shock, or heart failure. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner ce of): Examiner 2 meson e burial-trensit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) and physician s the burial Box 68760 MUCEN that the death certificate be Physician/Medical use es t 50 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Records, P.O. the deteched 23b. Did tobacco use contribute to the cause of death? signed by to do be detect (M.E.) 1 | Yes 2 | Ner 3 | Probably 4 | Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed peen page 2 May 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was cese referred to medical Be 26. Place of Death (Check only one) S Hospital: Other: 4 Nursing Home 5 ☑ Residence 6 Other (Specify) Franci 70 1X Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 23 Naturai 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Cartifying Phyalcien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier by Medical (Check only one) *Released 29d. Date signed (Month, Day, Year) 29b. Signature end till 29c. License number February 14, 1998 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John G. Lodmell, M.D., 2901 Olney-Sandy Spring Rd., Olney, MD 31. Date filed (Month, Day, Year)
FEB 171998 State Registrar



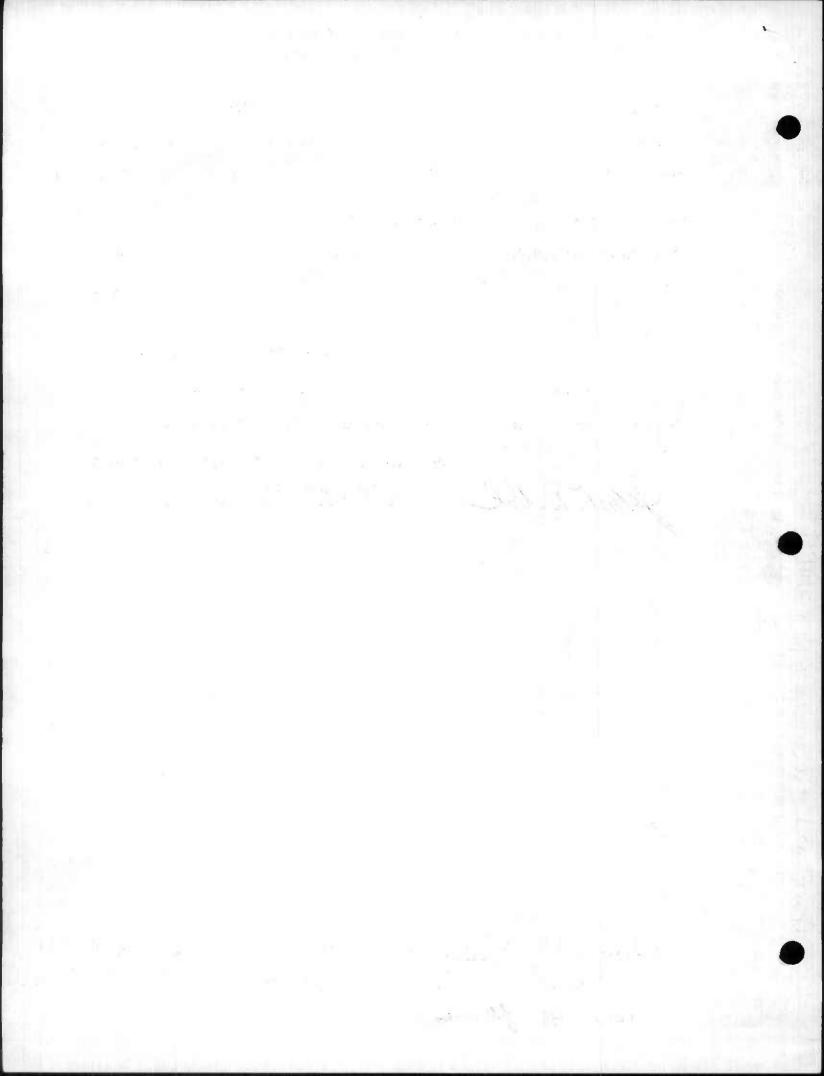
State of Maryland / Department of Health and Mental Hygiene

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	amin		4a. Facility Name (If						4b.	. City, Tov		ation of Death	4c. County	of Death		
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Dallimore, N permit. Peges 1 end Deperment of Health Important: if Item 27	any injury		21. Signature of Fun	erai Service Lic	ensee	1	2	2. Nama and	Address	of Facility	1	S	ILVER	SPR	ING.	MD.
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. 5 6	pd fo	Physician	Part II. Other algolflo	ant conditions	contributing to deat	th but not resu	ulting in the u	inderlying cau	ısa given	n In Part I.		23b. Did to	bacco uan co/	rtribute to	the cause o	of death!
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or Attending Faffer daeth.	o fu	Certification:	1 Natural 2 ☐ Accident	5 Pending investigat		Day (ear)	Injury	М		es 2 N	10					
Cto da cto	t t	fic	3 Suicide	6 Could not determine	286. Place of	Injury - At ho	me, farm, st	reet, factory,	office		2		reet and Numb	er or Rure	i Route Num	ber,
5 8 5	E E	ert	4 🗆 Homicide	4010111111	building	, etc. (Specify	1)					City or Town	n, State)			
To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After			29a. Certifier	Cartifying	Physician: To the be	set of my know	uladaa daat	h accurred of	the time	data and	l olego as	ed due to the e	(a) and		hada d	
Hos Fun	tely	edical	(Check only 2 one)	☐ Medical Ex	aminer: On the basi	s of examinat	ion and/or In	vestigation, in	my opir	nion, death	h occurre	d at the time, d	ate and place, a	and due to	tated. the cause(s	i)
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15	;		30. Name and address	ss of person wh	o completed ceuse	of death (Item	23a) (Type,	Print) A	-	2+	100	60:4	01		4 4 7	0.0
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State of Maryland / Department of Health and Mental Hygiene () Q

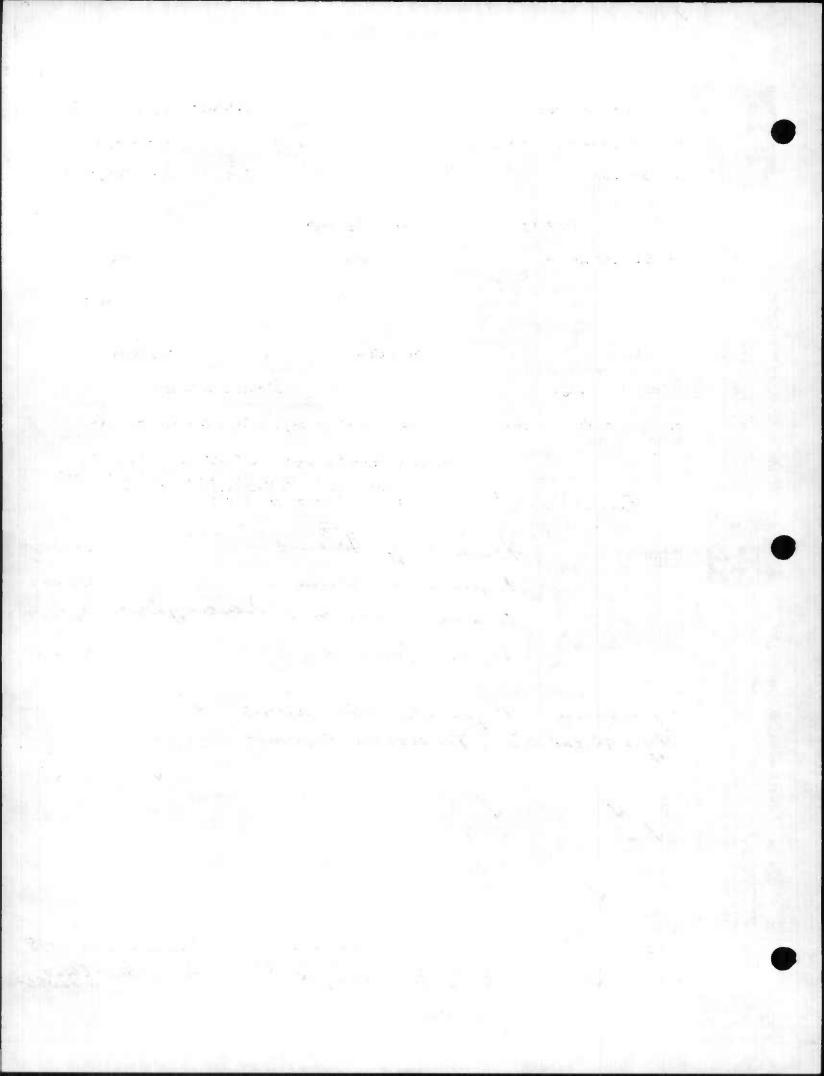
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Department of Health and Mental Hygiene. important: if item 23 is or 28a-f show important: if item 27 is marked other than "natural; or items 23 or 28a-f show any injury or other traumatic event, the Mojical Exercites must be inclifted at ance.	by Funeral Director	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Dec Armed Fo 1 Yas If Yes, Gi Yeer or D	2 ZNo ve		Was Deced If Yes, spec 1 ☐ Yes 2		Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Rad Ble Specif	ck, White,	can Indien, etc. ite	
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requires that the bean befinitiate be executed seen signed by the attanding physician end hould be detached for use es the burial-transit	ical Examiner	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Inflieted events resulting in death Leet	b	Due to (c	or es a consec	quenca of):							
attanding ph for use es th	Physician/Medical	resulting in death) Lest	d							- 14	-		
the at	/sic	Pert II. Other significant conditions of	contributing to de	eath but not res	ulting In the u	nderlying ca	use giv	ven In Pert I.	23b. Did	tobacco use co	ontribute t	o the cause	of death
igned by the a be detached (by Phy						-		10	Yes 2□ No	3□ Pro	bably 4	Onkno
s been s 2 should	Completed			145.		-			24e. Wes	en eutopsy med?	94	fere eutopsy veileble prior empletion of deeth?	10
pag									1 🗆 '	Yes 2 No	1	Yes 2	No
is certificate director, pag	Be	25. Wes case referred to medical axaminer?	Hospital:	1			011	26. Plece of Dee	th (Check only o	me)			
G is	70	1 Yas 2 No	169	-	ER/Outpetier			4 LI Nursing H	oma 5 Rasi			fy)	
Afte	ation:	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident Investigatio	n	of Injury th, Dey Year)	28b. Time o Injury	f 28	Sc. Injur Wor 1	ry et rk? Yes 2 □ No	28d. Describe	how injury occur	rred		
olre in b	Certification:	3 Suicide 6 Could not be determined	buildi	of Injury - At hing, etc. (Specif	γ)				City or To				nber,
24 hours after Funeral Dir letely filled in	edical	29e. Certifier 1 Certifying Pt (Check only one) 1 Medical Exar	niner: On the bi	best of my kno asis of exemine ner steted.	wledge, deet tion end/or In	h occurred e vestigation,	t the tir in my o	me, dete end plece opinion, deeth occu	, end due to the rred et the time,	ceuse(s) end m date end placa,	enner es s end due t	steted. o the cause(s)
within To the compl	Me	29b. Signature and title of certifier	A	1		29c.	Licens	se number		29d. Dete signe	ed (Month.	Dey, Year)	
s ⊢ ö		161.	Urk	Jones	nn	6							90
١	-	30. Name and address of person who	completed	e of death hu		Printi	, ,	M,11 R		rebru	1))	110
		Light address of person who	1260 =	1	2017	Vc.	. e	MILLE	J. Wh	actor	N	يل ور	196
		.00001. 00		4.4		N -1	1 5 5						



State of Maryland / Department of Health and Mental Hygiene

				Certif	icate of i	Death		Reg	. No.		6/9/
	1. Decedent's Name (First, Midd	lle, Last)						te of Deeth	Dev	Year	3. Time of Death
Physician	Betty Jean	Hall						ruary	18, 19		15:15
/Medical Examiner	4e Fecility Neme (If not institution		per)		4	4b. City, To	wn, or Location		4c. County		
Examiner	Montgomery Gen	eral Hospit	al			01ne	V		Mont	gomer	·v
Funeral	5. Sociel Security Number		Age (In yrs. last bir		Under 1 Year	If Under	24 Hrs. 8. Del	e of Birth	Sini -		ace (Stete or Foreign try)
Director	577-36-8183	1□ M 20XF	67	Yrs.	onths Days	Hours	Min. (Mc	onth, Dey, Y	1930	Mary	
	Usuel Residence of Decedent										2012
show at at	10a. State 10b. County	/	10c. City, Town	n or Location	on					10	Od. Inside City Limits
Mer To	MD Mont	gomery	S	ilvei	r Sprin	o					1 ☐ Yes 2 1 No
vith the Mer to c 28=1 s be northed Director	10e. Street end Number	5002/			IOI. Zip Code	0		100	. Citizen of V	Vhet Coun	try?
3a o	15201 Elkridge	e Way			20906				1	USA	
ofter death viner ment	11. Meritel Status	12. Wes Decede		13. Was		lispanic Ori	gin? (Specify Ye	s or No-	14. Race	e - America	
Fur Rec	1 Never Married 2 Mai	Armed Force	No No				, Puerto Rican,	etc.)	Blec	k, White,	etc.
DZ OURS	3 ☐ Widowed 4 ☐ Divorce	If Yes, Give Yeer or Date	es:	10	Yes 2⊠ No	Specify:			Specify	Wh	ite
and 21215-0020 be filed within 72 hours efter death with the Meryland stal Hygiena. sto other than 'natural', or items 23s or 28s-f show event, the Medical Evandor must be notified at Be Completed by Funeral Director	15. Deceder	nt's Education	16e.	Decedent	's Usuel Occup	etion		16	b. Kind of Bu	siness/Inc	lustry
	(Specify only higher Elementery/Secondary (0-12)	est grede completed) College (1-4	lor 5.)	life. DO	d of work done of NOT use retired	dunng mosi d)	of working				
212 Villa in the state of the s	12	College (1-4		memal	ker				Own Ho	ome	
be file be file d othe event,		, Last)				18. Mothe	r's Neme (First,	Middle, Ma	iden Sumem	10)	
lar lar ked be contable contab		gh .					Blanche	M. Wa	lker		
Maryland 2121 d 2 should be filed within th end Mental Hygiena. The marked other than traumatic event, the Me To Be Compl	19e. Informant's Neme/Reletion		19b	. Mailing A	ddress (Street	end Numbe	er or Rurel Route	e Number, C	City or Town,	Stete, Zip	Code)
Md 2 hd 2 27 is 27 is r tra	Frank L. Hall	(husba	nd) 15	201 E	Elkride	e Wav	, Silve	r Spri	ng. Mi	0 20	906
Haalth Haalth Hem 27 I	20a. Method of Disposition	(IIGBDG			on (Neme of ory or other plea		Dete	-	c. Location -		wn, State
ages int of ror of	1 Buriel 2 Cremetion		ate				2/21	/08 P	ckvil	1.0 1/4	D
Baltimore, N permit. Pages 1 and Department of Haalth Important: If item 27 any injury or other to page.	4 Donetion 5 Other (S		Рагкта		emorial					-	
Ba Banda Ban	21. Signatura di Fullerei Service	Licentee		Home	e, Inc.	500	y Franc: Univer	sity E	sivd.	West	nerar
	Oleven	trond		Silv	er Spr	ing, l	MD 2090	01			
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Physician		0	1		12.	,	7				Onset end Deeth
/Medical Examiner	Immediete Ceuse (Finel diseese or condition	tes	per axo	ny	June	une	· ·				16 NOVS.
	resulting In deeth)		Due to (or es e	consequen	nca of):						
2 %		- Emy	shysen	ed	Seno	al .	-			- 1	years.
axecuted in end iel-trensit	Sequentially list conditions,		Due to (or es e	consequen	ica of):	/ -	Pula	. An Qu	405	200	16 Days.
e axe dian e uriel-	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events	Cha	onie o	Olio	Truct	und			1	1	Jears.
I Records, P.O. Box 68760, The law requires that the death certificate be axecuted at has been signed by the ettending physician end page 2 should be datached for use as the buriel-trensit completed by Physician/Medical Examir	that initiated events resulting in deeth) Lest	C.	Due to (or es e								1 -
x 68 entifica	Toolking it doonly book	Atr	ice E	Dro.	schol	1					16 NAG
Box eath cert ettendin for use		d									
P.O. Boy et the death of d by the ettend atached for us Physiclan/	Pert II. Other significant conditi	ons contributing to deat	th but not resulting in	the under	rlylng cause giv	en in Pert I	. 2	3b. Did tobj	ecco use con	ntribute to	the cause of death?
P.O. the the de by the datached	Hyperstens	2. 7/2	0-01		Samo	del	mis	1 N Y 88	2 No	3 Prot	sably 4 Unknown
s the s the day		1 2	general	· ·	7,500	-					
The law requires the law requires the law been signed page 2 should be dat Completed by P	Hyperglises	almie	Vente	lax	wy 50	uppo	nl- 26	la. Was an		24b. We	ere eutopsy findings eilable prior to
w re w re shoet shoet	1)						performe	id i	cor	mpletion of cause death?
Reclay be has age 2								1 Yes	2 10 No	10	Yes 2DNo
						00.51	10 0 10		2 140		1165 242140
	25. Wes case referred to medica exeminer?	Hospitel:			on DOA Oth	er	of Deeth (Chec		. To:	40	
0 = ==	1 Yes 2 No 27. Menner of Deeth	28e. Dete of	patient 2 ER/Ou	tpetient :	3LI DON	4 🗀 140	rsing Home 5		injury occur		/)
	1 Neturel 5 Pendi	/A Annah		njury	28c. Injur Wor	k? Yes 2□			injury cood.		
Division or Attending after deeth. Director: After d in by the fune	3 Suicide 6 Could	not be	f laiun. At home fe					cation /Stra	et and Numh	er or Buci	l Route Number,
Division of Attendant after deet Director: Jin by the ertifical	4 ☐ HomicIde determ	nined 200. Pleca of building	f Injury - At home, fa , etc. (Specify)	m, street,	lectory, office			y or Town,		or bi ridia	r ributa reambor,
Taris O											
n 24 hou n 24 hou ne Fune pletely fil	(Check only 2 Msdical	ng Physician: To the be Examiner: On the basi	is of examinetion en								
To the Hospital within 24 hours a To the Funeral I completely filled	One)	end manne	r stated.		29c, Licens	a number		20-	I. Date signe	d (Month	Dov Year
OT NO TO	29b. Signeture and title of certific	/amless	min					100	400 1000		
15	10 lines				225	410		14	UKu	my 1	8.1778
	30. Neme end eddress of person	who completed cause	of deeth (Item 23e)	Type, Prin	nt)	101	. To	PI	0,07	Ruis	06 EY mo 20832
	OliVER V.	LAWIESS				18/11	Mence	In	413		mo 20832
State	31. Date filed (Month, Day, Year	32. Reg	gistrar's Signeture	0. 0.00	,						
Registrar	FEB 20	1998	a variation	anjore							

DHMH 16 Rsv 6/95



Please

Same as 10 20b. Plece of Disposition (Name of cemetery, cremetory or other plece)

22. Neme end Address of Fecility

Rapp Funeral Services, P.

			d / Depa	rtment of	c. Assure A Health and N		_	ible.	06798	
ast)				tificate of	Death	2. Dete of Deeth Month	Dey	Yeer	3. Time of Deeth	
Geor	_	Joh	n Hal		4b. City, Town, or L	February ocation of Deeth	4c. Count	y of Deet	6:52 AM	
oad					Betheso	la	Mont	gomer	^y	
Sex 1XIM 2□F	7. Age	(In yrs. le	est birthday) 4 Yrs.	Months Deys		8. Date of Birth (Month, Pay, OCt. II,	Year) 1913	9. Bird Co Penr	hplece (Stete or Foreign untry) ISYIVania	
mery			, Town or Loc hesda	ation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
ad				10f. Zip Code 20817			og. Citizen of Inited			
12. Wes Deced Armed Ford 1 Yes 2 If Yes, Give Yeer or De	ces? 2 💢 N		If	Vas Decedent of Yes, specify Cul	Hispanic Origin? (Sp ben, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ock, White	rican Indien, e, etc. i te	
ducation ede completed)			(Give k	ent's Usuel Occu	e during most of work	ina	6b. Kind of I	Business/	Industry	
College (1-	4or 5+	.)	`life. D	neer	ed))epartı	ment	of Navy	
)					18. Mother's Nem		-		•	

Elizabeth Zeilberg

Dete

Gate of Heaven Cemetery 2-17-98 Silver Spring, Maryland

20c. Location - City or Town, State

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nnknown

24e. Wes en eutopsy performed?

1 🗆 Yes

2 No

Approximete Intervel Between Onset end Deeth

19 years

24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth?

1 ☐ Yes 2 No

19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Inspartment of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified one. Baltimore, Maryland 21215-0020 **Physician**

/Medicai Examiner

To the Hospital or Attending Physician: The law requires that the death certificeta be executed within 24 bours after death.
To the Pureral Director: After this certificate has been signed by the attending physician and completely filled in by that function, page 2 should be deteched for use as the burlar-transit completely filled in by that function;

Division of Vital Records, P.O. Box 68760,

	ı
Examiner	
hysician/Medical	
Completed by F	
To Be	
tlon	

1. Decedent's Neme /First, Middle, L.

4e. Fecility Neme (If not Institution, gi

5. Sociel Security Number

10a State

Maryland

11. Maritel Status

10e. Street end Number

577-18-8038

Usuel Residence of Decedent

9312 Fernwood R

9312 Fernwood Ro

1 Never Married 2 Married

15. Decedent's E

19e. Informant's Name/Relationship (Type, Print)

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State

Hall

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondery (0-12) 12 17. Fether's Neme (First, Middle, Las

George James

Virginia M. Hall

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signeture of Funerel Service Licensee

20a. Method of Disposition

10b. County

Montgo

Physician /Medical

Examiner

Director

by Funeral

Completed

Be 10

Funeral

Director

933 Gist Avenue, Silver Spring, MD 20910
d the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest,
Approx 23a. Pert1. Enter the disease, or complications there us conshock, or heart feilure. List only one cause on each life. Immediete Ceuse (Finel diseese or condition resulting In deeth) Bladder Carcinoma Due to (or es e consequence of) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Medical Certifica 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

(wife)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Dey, Yeer) February 16, 1998 D04766

10400 Connecticut Avenue, Kensington, MD

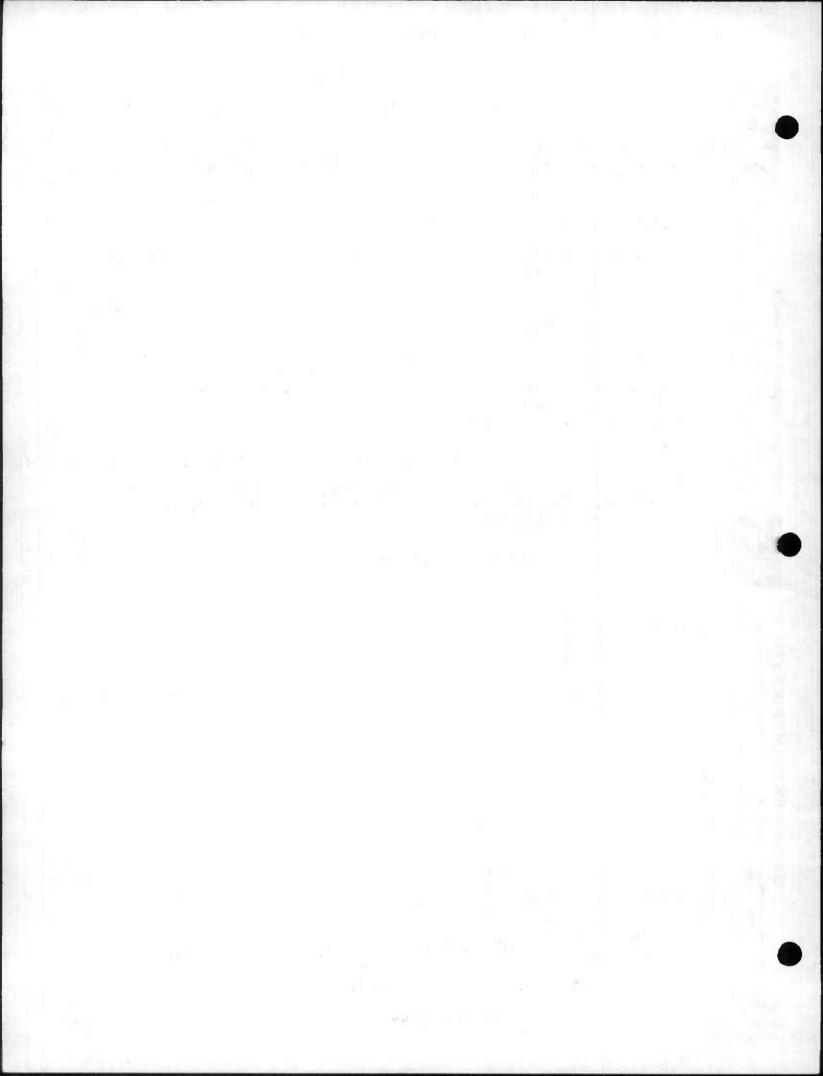
Daniel Rosenblum, 31. Date filed (Month, Dey, Year) State FEB 17 1998

Davids

D., 32. Registrer's Signeture

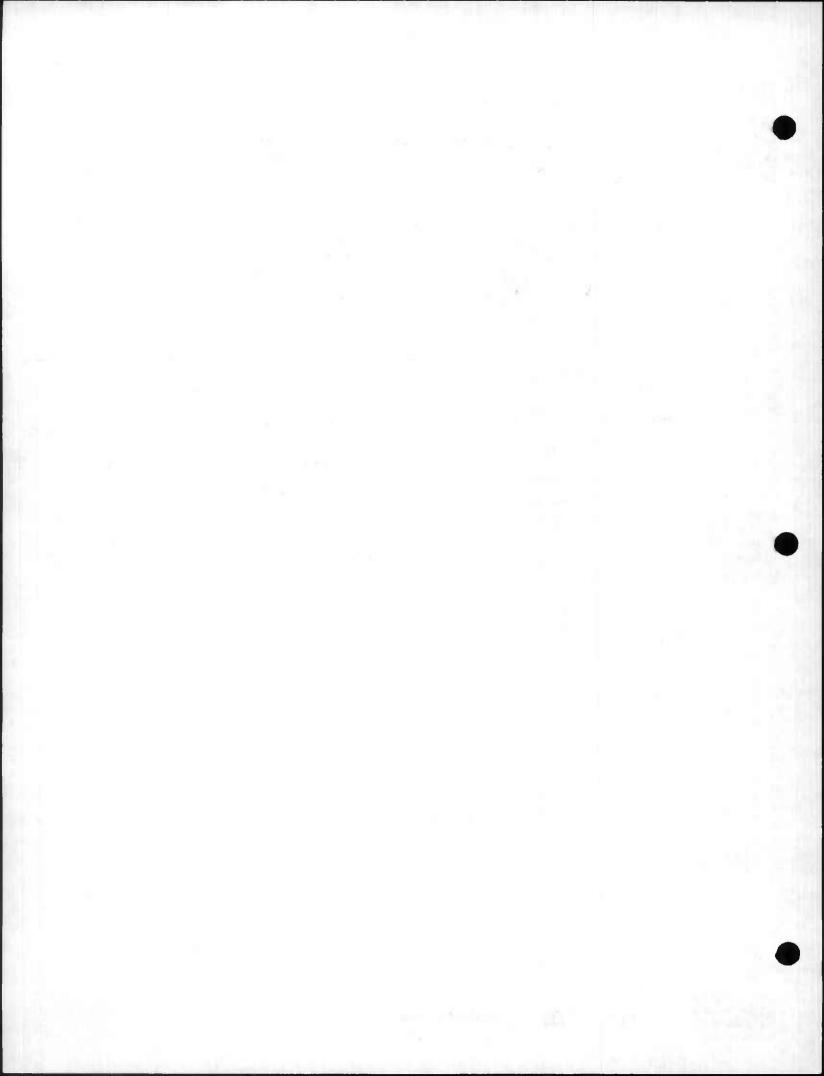
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) #606

Registrar



State of Maryland / Department of Health and Mental Hygiene Q 0 6 7 0 0

Dharak		1. Decedant's Nama (First, Middle, L	1					2. Date of Dae	Reg. No. oth Day	Yaar	3. Tima of Dea
Physici /Medi		Joseph F	fartman					February	1 13, 19	198	0942
Examir		4e. Fecility Nema (If not institution, g	iva straat and numbe	r)			4b. City, Town, or L		-		
Exami		SHADY GROV	E ADVENT	TST	HOSPIT	AT.	ROCKVII	T.T.E	MON	TGOME	DV
Funeral					last birthday)	lf Undar 1 Year	If Under 24 Hrs.	8. Data of Birtl (Month, Da)			ca (Stata or Fo
Director		128-14-6565 Usual Rasidanca of Dacedant	1 ⊠ M 2□ F	71	Yrs.	Months Deys	Hours Min.	June 28		New New	
r 28a-f show notified at	or	10e. Stata 10b. County			ity, Town or Local	tion				100	I. Insida City L
288	Director	Maryland Montgon	nery	Ro	ckville	10f. Zip Coda			10g. Citizen of N	Affron County	.0
0 8	ā										y r
s 23a	era	5432 Marlin Stre	12. Was Daceder	4 Fires in 1	1.6 40.146	20853	liananta Origina (Or		U.S.A	• e - Amaricar	Ladina
P, or Rema	by Funeral	Navar Married 2 Marriad Widowad 4 □ Divorcad	Armed Forcas	?		as, specify Cub	dispanto Origin? (Span, Maxican, Puarto Specify:	Rican, atc.)	Specify	ck, Whita, at	
n "natural", Jeolical Ex	Be Completed	15. Decedant's l (Spacify only highast g	Education rade complatad)		16a. Decedan (Giva kin lifa. DO	t's Usual Occup d of work done NOT usa ratire	pation during most of work d)	sing	16b. Kind of B	usinass/Indu	stry
than than	E	Elamantary/Sacondary (0-12)	Collaga (1-4o	r 5+)	Agent				Secret S	Servic	0
other vent,	O	17. Fathar's Nama (First, Middla, Las	(1)		ngen	ber .	18. Mothar's Nam				<u></u>
thealth and Mental Hyg tem 27 is marked other other traumatic event,	To B	Hyman Hartman						y Schnui			
E SI		19a, Informant's Name/Ralationship					and Number or Rui			Stata, Zip C	ode)
em 27 i		Toby S. Hartman	(wife)		5432 Ma	arlin S	t. Rockvi	lle, Man	cyland	20853	
ent of ru nt: if Iten ry or oth		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ⁴ 4 ☐ Donation 5 ☐ Other (Spec		a	Ptaca of Dispositi comatary, cramai ernal Lig		1	Data /15/98	Boynton		
Unportant: if Item 2 any Injury or other once.		21. Signatura of Funaral Sarvice Lice		1100	22. N	ama and Addre	ss of Fecility ky-Goldbe	rg Memoi	cial Cha	apel	
		230 Part Fater the disease or on	nollastians that save	od the dee	th. Do not enter	1170 Ro	ckville P	ike Ro	ckville		
	1	23a. Part1. Entar tha disaasa, or con shock, or haart failura. List ont	y ona causa on aach	lina.	tn. Do not antar	na moda or dyr	ng, such es cerdiac	or raspiretory en	rast,	ĺ	Approximata Interval Between Onsat and Dec
ysiclan ledical	0	Immadiata Causa (Final	^		A.1 #	V.I	isease				70
aminer		diseasa or condition rasulting in death)	a. C	LoNa	iry art	ely o	1126026				30 ye
	ē		-		or as a consequa						
1Sit	ulu		1 b	iabet	es melli	tus					5 year
end el-tra	xar	Sequantially list conditions, if eny, laading to immediata		Dua to (or as a consequa	nca of):					
physician end s the buriel-transit	edical Examiner	Sequantially list conditions, if eny, laading to immediata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants	c								
phys the	dic	resulting in death) Last		Dua to (or as a conseque	nce of):				į	
O) (d)	95	· ·	d							i	
for u	lan										
the	ysic	Part II. Other algorificant conditions	contributing to death	but not ras	sulting In the unde	rlying causa gi	van in Part I.	23b. Dld t	obacco use co	ntribute to ti	he cause of c
been signed by the ettendin should be deteched for use	by Physician/							101	res 2□ No	3 Probe	bly 4 ⊉Un
sign ld be	Q Q							24a. Was a	an autopsv	24b. Wara	a autopsy find
shou	Completed							perfor	med?	comp	abla prior to plation of cau:
has ge 2	E D									of da	
cate pag								1 🗆 Y	as 22No	10'	Yas 2□ No
: certificate has b firector, page 2 s	Be	25. Was casa rafarrad to medical axaminar?	Hospital:			10	26. Placa of Deat	th (Check only or	na)		
this c	2	1 Nas 2 No	Hospital: 1 ☐ Inpa			3LI DOA		ome 5 Resid			
x: After the funeral		27. Mannar of Death 1 Natural 5 Panding 2 Accident		jury a <i>y Yaar)</i>	28b. Tima of Injury	28c. Inju Wo M 1□	ryat rk? Yes 2 □ No	28d. Dascribe h	ow Injury occur	red	
al Directo	Certification:	3 ☐ Suicida 6 ☐ Could not 4 ☐ Homicida datarmina	28a. Placa of I	njury - At h itc. (Speci	oma, farm, straat	, factory, office		28f. Location (S City or Tow		per or Rural F	Routa Numbe
With 24 hours after begin. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Cartifiar (Check only one)	hysician: To the bas minar: On the basis and mannar:	of axamina	owladga, daath oo ation and/or invas	ccurred at tha ti tigation, in my c	ma, data and place, ppinlon, daath occur	and dua to tha c red at tha tima, c	ausa(s) and mo data and place,	annar as stat and dua to th	ad. na causa(s)
Toth	Ž	29b. Signeture and title of curtifier	0/			29c. Licens	se number		29d. Data signa	d (Month, Da	ay, Year)
		1200	CM	.0.		D	46741	1	February	13, 1	998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Day Yaar Hollenson WILLIAM Jose PH February 13,1998 6:20 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death | Gaithersburg | T. Aga (In yrs. last birthday) | If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 401 Russell Avenue, # 409 Montgomery 5. Social Security Number Birthplace (Stata or Foraign Country) 6. Sex Months Days 1 M 2 □ F Yrs. 81 July 8, 1916 New Jersey 058-14-1308 Usuel Rasidance of Daceden 10d. Insida City Limits 10a State 10h Counts 10c. City, Town or Location 1 TYas 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 401 Russell Avenue, # 409 20877 United States 12. Was Decedant Ever In U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 1 ⊠ Yas 2 □ No If Yes, Giva Yaar or Dates: 1943/1946 1 ☐ Naver Married 2K Married 1 ☐ Yas 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Dacadant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Collega (1-4or 5+) Elamantary/Sacondary (0-12) 5+ Civil Engineer Engineering 18. Mothar's Nama (First, Middle, Meiden Sumama) 17, Father's Nama (First, Middle, Last) Elmer Hoffman Elizabeth Kane 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Reletionship (Type, Print) 401 Russell Ave., # 409, Gaithersburg, MD. 20877 Marie Hollenbach Hoffman/Wife 20b. Place of Disposition (Nama of cemetery, crematory or other place) Data 20c. Location - City or Town, Stete 20e. Mathod of Disposition 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 2/15/98 Alexandria, Virginia Metropolitan Crematory 22. Name and Addrass of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee Wen 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Pert1. Enter the disaesa, or complications that caused the death. Do not anter the mode of dying, such es cardiac or raspiratory errest, shock, or heert feilure. List only one cause on each line. Approximate Interval Batween Onsat end Death Immediata Causa (Final disaesa or condition rasulting in daath) Instulnya Effusion Saquantially list conditions, if any, leading to immadiata causa. Entar Undarlying Ceuse (Diseese or Injury that Initiated evants rasulting in daath) Last Dua to (or es a consequence of): Due to (or es e consequenca of): 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Winknown 24b. Wara autopsy findings avellable prior to 24a. Was an autopsy performed? complation of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical exeminer? 26. Pleca of Death (Check only one) Yas 2 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

physician end the buriel-transit certificate be axecuted 68760 requires that the deeth P.0. the signed by Deen cartificate this funaral

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Examiner Physician/Medical ð Be Certification: To

27. Manger of Death

1 Avatural 2 Accidant

3 ☐ Suicida

29a. Cartifiar

4 Homlcida

(Check only one)

DOYFLAS

29b. Signeture end title of certifier

Physician

/Medical

Examiner

Director

Funeral

by

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Exerciser must be notified at

filed within 7 Hygiena.

h end Mental I

permit. Pages 1 and 2 st Department of Health enc Important: If Item 27 is m any injury or other treun

Physician /Medical

Examiner

the Maryland

Director: After death. ò filled in 1 24 hours e To the I within 2. To the 8 complet 15+1

> State Registrar

edicai

31. Dete filed (Month, Day, Year)

R

5 Panding Invastigation

6 Could not ba

SHUMBEREN. MO. 32. Registrer's Signetura Jula Leigher

28b. Tima of

28a. Placa of Injury - At homa, ferm, straat, factory, office building, atc. (Spacify)

28a. Deta of Injury (Month, Dey Year)

Dougla & Pluman, mo

75300

28c. Injury at Work?

Cartifying Physicien: To the best of my knowledge, deeth occurred at the time, data and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated.

29c. Licensa number

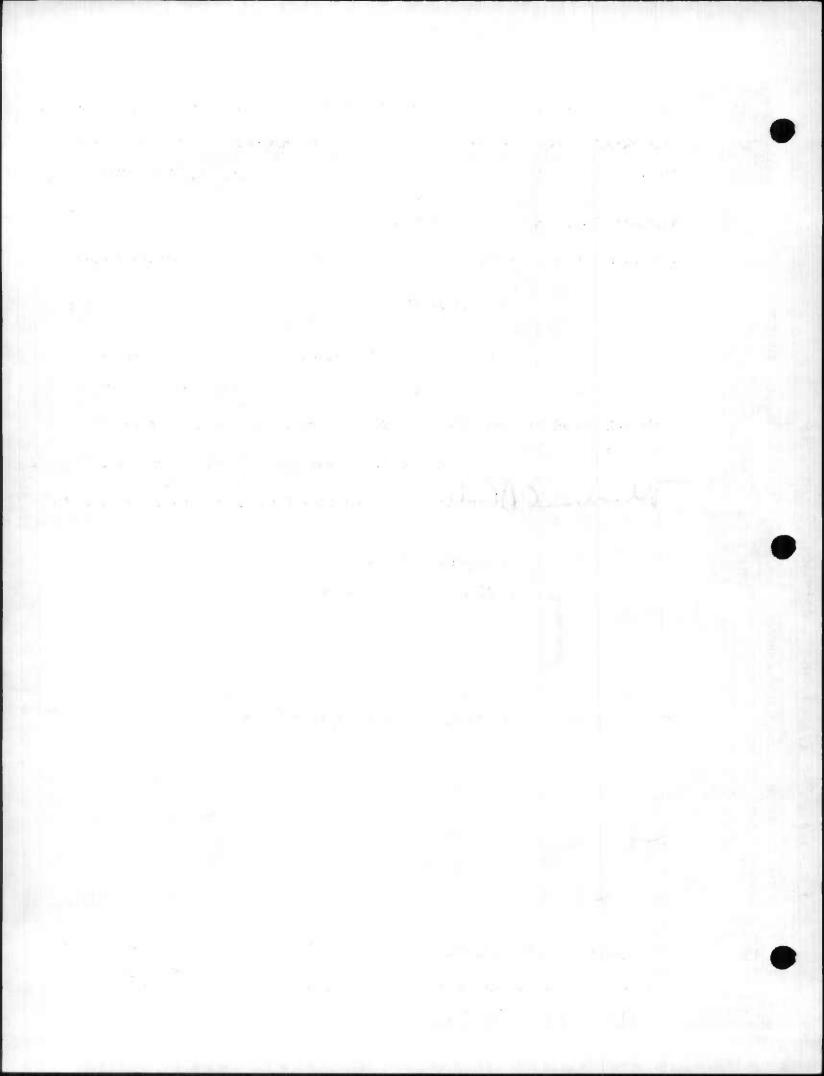
1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signad (Month, Day, Year)

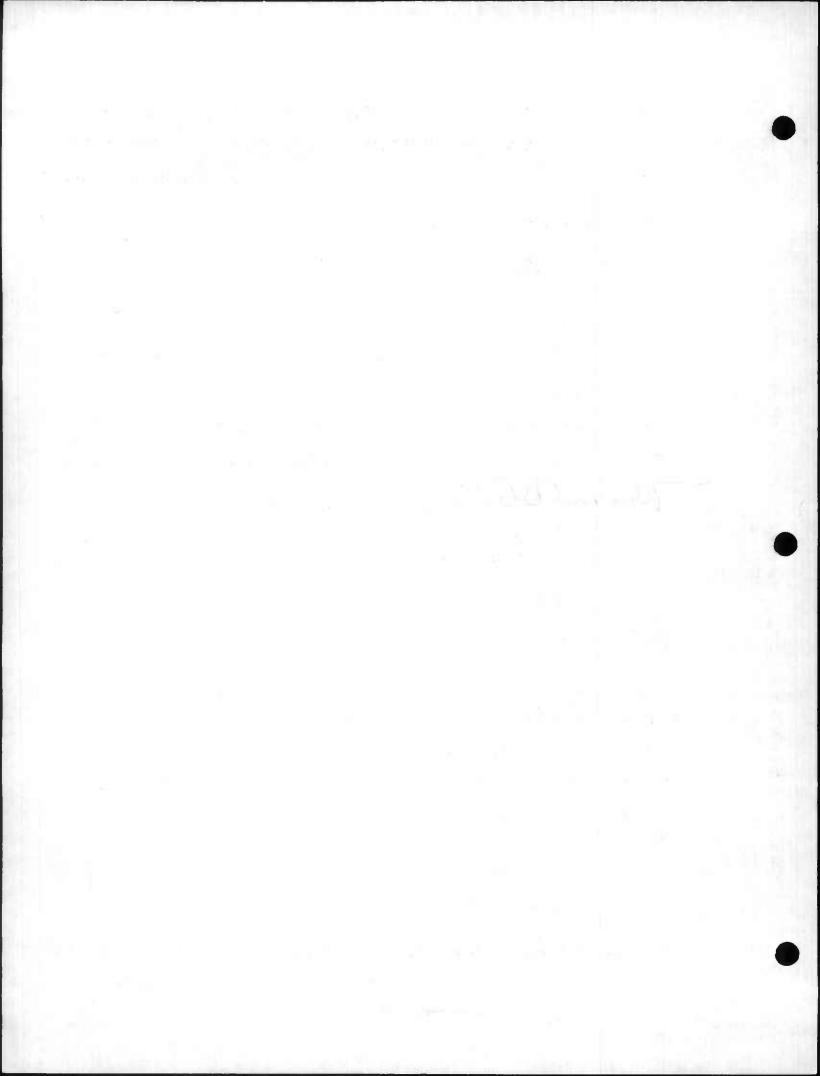
28d. Describe how Injury occurred

30. Neme end eddrass of person who complated causa of daeth (Item 23e) (Type, Print) 6/5 . And NTOOMBEY Print) 100 208,0 ROCKULLE



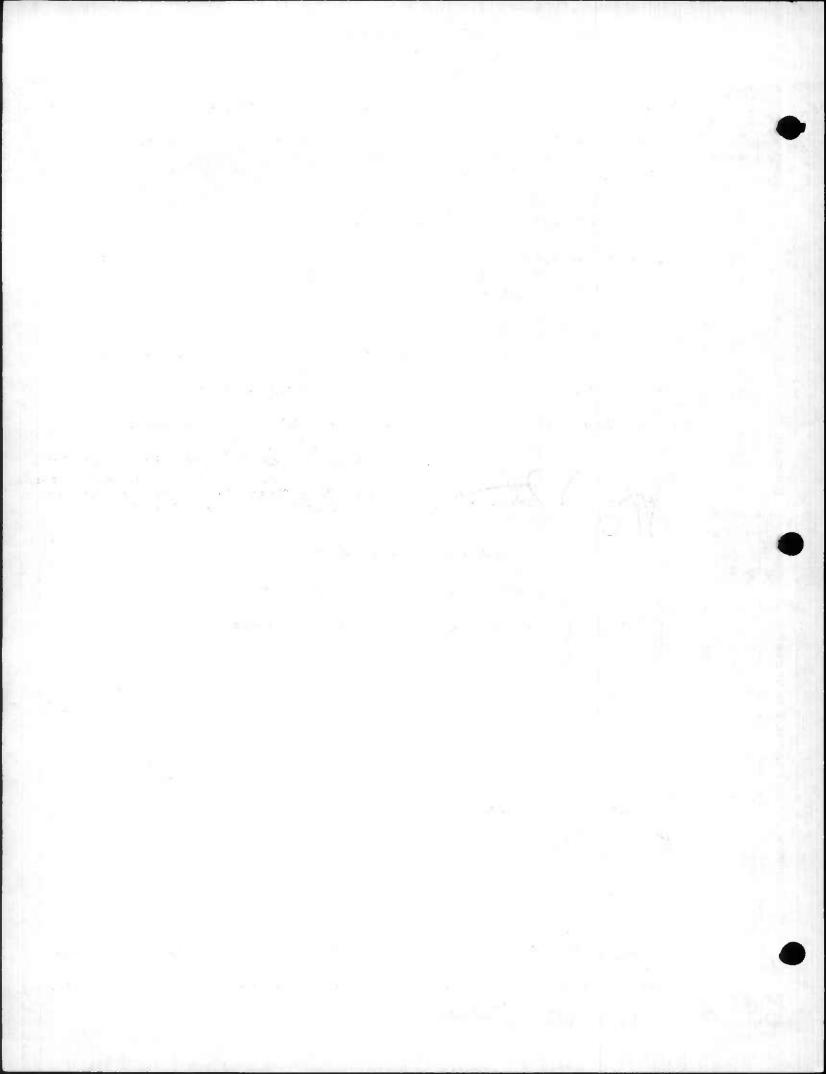
State of Maryland / Department of Health and Mental Hygiene 0 8

					,	Certificate		R	leg. No.	06801	
	Physic /Medi	cal	Decedent's Neme (First, Middle, L Lester Aa. Fecility Name (If not institution, g.	Jilson		Hott	nger 4. City, Town, or Lo	2. Dete of Dee Month Februar	th Day	Year 1998 0010 A	
	Exami Funeral Director	ner	SHADY GROV: 5. Sociel Security Number 6. 578-01-3754	E ADVENT	IST HOS ge (In yrs. last bir	thdey) If Under 1 Y	ROCKVII	LE 8. Date of Birth (Month, Day	MONT.	PGOMERY 9. Birthplace (State or Foreign Country) West Virginia	
	Marylend a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgon	nery	10c. City, Town	or Location				10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	eth with the Marylen s 23s or 28s-f show must be notified at	rai Director	10e. Street end Number 13207 Chalet Pla				0874		Og. Citizen of V	States	
020	72 hours effer deeth with the Maryland natural, or items 23a or 28a-f show olds Examinar must be notified at	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces 1 Yes 2 If Yes, Give Yeer or Detes:			of Hispanic Origin? (Spe Cuben, Mexicen, Puerto No Specify:	ecify Yes or No- Rican, etc.)		e - American Indien, k, White, etc. : : White	
21215-0020	within 72 hours eft ene. then "natural", or i	Completed	15. Decedent's E (Specify only highest gi Etementary/Secondary (0-12)	Education rede completed) College (1-4or	5+)		ccupetion one during most of worki etired)	ing		siness/Industry	
	be filed itel Hygi of other event, I	To Be Co	17. Father's Neme (First, Middle, Las	n larvey Hoti		arpenter	(First, Middle, I	Malden Sumem	f the Navy owry		
, Maryland	d 2 sh th end 7 is m traum	1	19e. tnforment's Neme/Relationship Frances V. Hotti	(Type, Print)	19b.		treet end Number or Rura	al Route Number	r, City or Town,	State, Zip Code)	
Baltimore,	T H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Content of the Content	Removel from State	20b. Place of cemeter	Disposition (Neme of y, crematory or other ke's Church	of r place)	Dete	20c. Location -	City or Town, State Maryland	
Bal	permit. Pa Depertmen Important: any injury		21. Signature of Funeral Service Lie	D.Cul	lay	10 East I	Deer Park Di	Vol Func	hersbur	g, MD. 20877	
	Physiclan /Medical Examiner	Jr.	23a. Pert1. Enter the disease, or conshock, or heert failure. List only Immediate Cause (Final disease or condition resulting in deeth)	0	monia	consequence of):	dying, such es cardiac d	or respiratory erro	est,	Approximete Intervel Between Onset end Deeth	
Box 68760,	certificate be executed nding physician end use as the buriel-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that inklated events resulting In death) Lest	b	Due to (or es e c						
P. O.	ires thet the death cer signed by the ettendir d be detached for use	by Physician/M	Pert II. Other signiffcent conditions Chronic (BSW)			23b. Dld to	b. Did tobacco use contribute to the cause of death				
Records,	peen shoul	Completed by	cardiomyogathe	, renel	24e. Wes e		24b. Were eutopsy findings eveileble prior to completion of cause of death?				
Vital Re	The ete h page	Be	fan cytopenia 25. Wes case referred to medical exeminer?	Man hat			26. Plece of Deeth	1 ☐ Ye	/	1 ☐ Yes 2 ☐ No	
Division of	Attanding Ph death. ctor: After th y the funeral	Certification: To	27. Manner of Deeth 1 Naturel 2 Accident 3 Suicide 4 Homicide	28e. Piece of Inj	y Year) 28b. T		fnjury et Work? 1 Yes 2 No	me 5 Reside 28d. Describe ho 28f. Location (St City or Town	ow injury occurr		
	To the Hospital or within 24 hours efter To the Funeral Director Completely filled in the Funeral C	edicai									
)	1000 P	M	29b. Signeture end title of certifier	Range	Es M	0 29	cense number		- 1	1 (Month, Dey, Year)	
	Sta	te	30. Name end eddress of person who ALAN S. CHANACE 31. Date filed (Month, Day, Year)	15215	SHADY 6	ROVE RD	RUCKUILL	E MO	2083	50	
	Registr		FEB 17 1998	Juliante	ar's Signeture	MARIE					



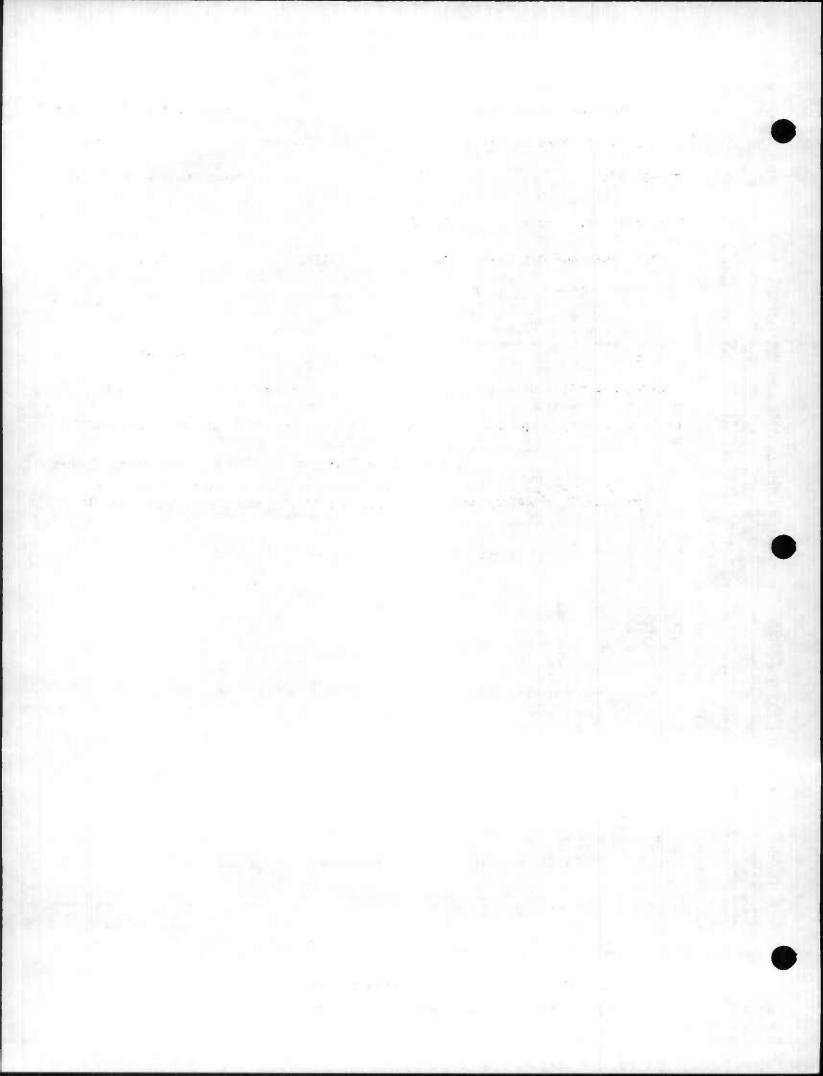
State of Maryland / Department of Health and Mental Hygiene O O

Physici /Medi		1. Decedent's Neme (First, Middle,	Last)	100			2. Date of Dea	Reg. No.		3. Time of Dea
		Sandra	М.		Hubba		Month	y 11, 19	Yeer 998	5:20 PI
Examir		4a. Fecility Neme (If not institution,	rive street end number)			4b. City, Town, or L	1			3.20 11
_Aa		Suburban Hospit	al al			Bethesda	ı	Montg	omer	v
Funeral Director		163-34-3460	Sex 7. Age	(In yrs. lest bi	Yrs. If Under 1 Year Months Deys		8. Dete of Birt (Month, De) July 28	h , Year)	9. Birthp	iace (Stete or Fo
*_		Usual Residence of Decedent 10a, State 10b, County		10c City Tow	m or Location				14	0d. inside City Li
유통	5	10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Chevy Chase					- '	1 Nes 2 □		
288	Director	Maryland Montgo	lie Ly		Chevy Chase					
0 8	ā				10f. Zip Code			10g. Citizen of W		
# 23	erai	4601 North Park			20815	15		United :		
Department of Health and Mental Hygiena. Important: if items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examine must be nutified at once.	by Funeral	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorcad	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N if Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub		Rican, etc.)	Specify:	k, White,	an Indian, etc. nite
cal L	Ped	15. Decedent's	Education	16a	. Decedent's Usuei Occu	pation		16b. Kind of Bu	siness/inc	dustry
Med .	Completed	(Specify only highest	rade completed)		. Decedent's Usuei Occu (Give kind of work done life. DO NOT use retire	during most of worked)	king			,
r the	Eo	Elementary/Secondary (0-12)	College (1-4or 5- 2		ecretary			U.S. Gov	vernn	nent
office Tr	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's Nam	e (First, Middle,	Maiden Sumem	θ)	
Menta Ked Isc ev	To B	John J. Hubba				Marie N	1. Wilco	x		
nd N mer	-	19e. Informant's Name/Reletionship	(Type, Print)	19b	o. Mailing Address (Stree				Stete, Zip	Code)
27 la		Marie M. Hubba/M	other		Sherwood St					
nent of Hea int: if item: iry or othe		20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3	Removal from State	20b. Piaca o camete	f Disposition (Neme of ry, cremetory or other ple	селFeb. 14.	Date 1998	20c. Location - 0	City or To	wn, State
nitra i		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lit		St. Pe				Wellsbor		
Depariment important fr		1 Jetter /	400689	A	22. Name end Addr Bethesda-C Be not enter the mode of dy	hevy Chas	e, Inc.	7557 W	isco	eral Hon
aminer -transit	Examiner	disease or condition resulting in death) Sequentially list conditions,	METAS	Oue to (or as a	consequence of): LUNG consequenca of):	CANCER FAILL				
iding physician and ise as the burial-transit	Medical	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In death) Lest	c. MULTE	-	consequence of):	FAIL	VRE			
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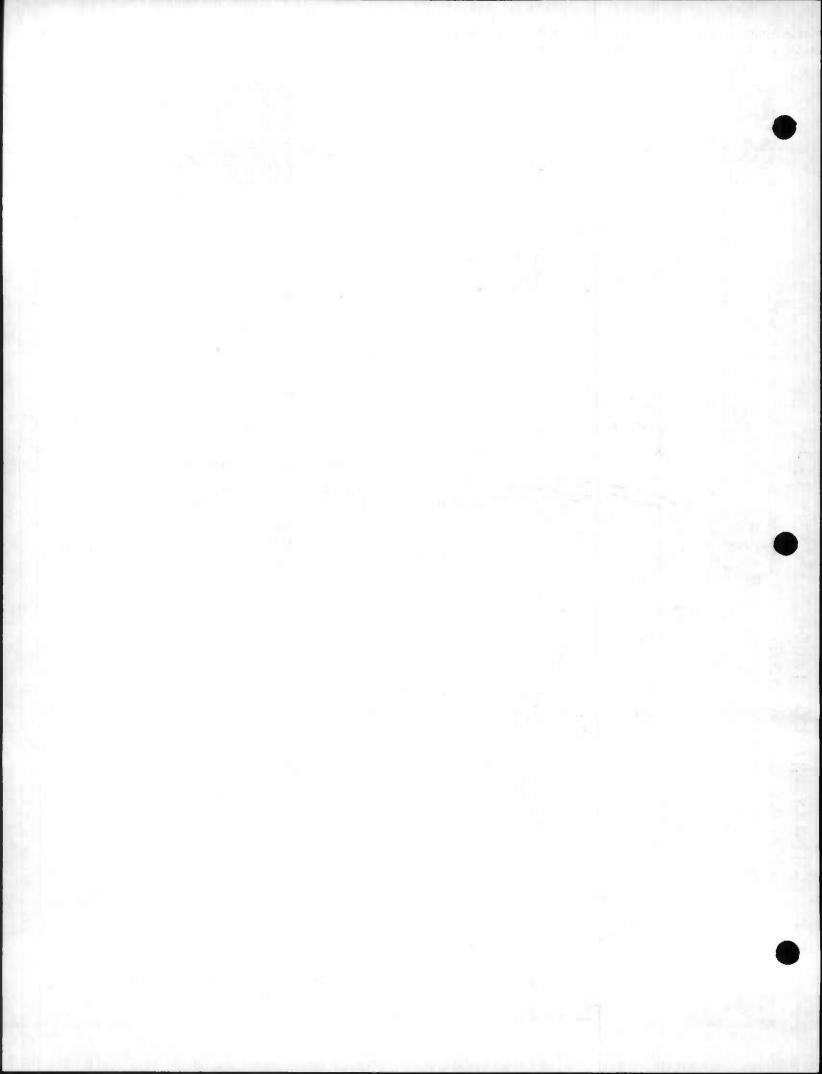
State of Maryland / Department of Health and Mental Hygiene

					Cert	titicate	of Death		Reg. No.	0 0000				
	1. Decedent's Name (First, Middle, Last)							2. Date of Deeth Month Dey Year 3. Time of Death						
Physician /Medical	M	lary Cath	erine Harr	is					ary 15,					
Examiner		_	give street and numbe				4b. City, Town,	or Location of Dea						
	St. M	lary's Nu	rsing Cent	er			Leonar	dtown	St.	Mary's				
Funeral	5. Social Security		. Sex 7. A	ige (In yrs. la	st birthday)	If Under 1				9. Birthplace (State of Country)				
Director	214-03-6 Usuel Residenca		1□M 2□XF	8	83 Yrs.	Months D	Days Hours M		24, 1914					
A W	10a. Stete	10b. County		10c. City,	Town or Loc	ation				10d. Inside Ci				
to to	Maryland	St. Ma	rv's	Cal	liforn	ia				1 ☐ Yes				
or 28a-f e be notified Director	10e. Street and N					10f. Zip Co	ode		10g. Citizen of	What Country?				
3a O		Chastant	Oals Count	#1000		20	619		U.S.	A				
Ter Jers	11. Marital Stetus		12. Wes Deceder Armed Forces	t Ever in U,S			t of Hispanic Origin? Cuben, Mexican, Pu	(Specify Yes or N		ce - American Indian,				
than "natural", or items 23s or 28s-f show he Medical Examiner must be notified at ompleted by Funeral Director		1 Never Married 2 Married 3 Widowed 4 Divorced		(No		Yes, specify		erto Rican, etc.)	Specify Specify					
ene. than "natural", he Medical En	02711001100	15. Decedent's	Year or Dates		16a Dacada	ent's Usual C	accupation		16b Kind of B	White Business/Industry				
ygiene. er than "natura t, the Medical Completed	(Sp	(Specify only highest grade complete			(Give k	aind of work of NOT use r	done during most of i	vorking	TOD. THIS OF D	don'to da ilidada y				
then the	Elementary/Se 8 t l		College (1-4o	5+)					D					
ISE a	17. Father's Nam	e (First, Middle, La	st)		010	erk	18. Mother's N	lame (First, Middle		ment Store				
D S S		ncis Mill						Miles						
traumatic e		Neme/Reletionship			19h Mailine	Address /C	treet and Number or		ber. City or Town	State, Zin Code)				
trau trau														
Department of Health Important: If Item 27 I any Injury or other tr DDCS.	Lloyd R.	Harris	/ Spouse	20b. Pla	23254 (ace of Dispos			#1008 Cali		- City or Town, State				
P F P	1 S Burial	2 Cremetion 3	☐Removal from Stat	COC	metery, crem	etory or othe	r place)	1	Loo. Lood(o)	Only or Form, Claro				
tant		5 Other (Spec	**	Char				2/17/98	/17/98 Leonardtown, Maryland					
por por y in	21. Signature of	21. Signature of Funeral Servica Licensee Charles Memorial Gardens 2/17/98 Leonardtown, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A.												
6 4 2 0.	Mic	hael	Darden	car)		_			ardtown, Maryland 20650					
	23a. Part1 Ente	the disease, or co	emplications that causely one ceuse on each	ed the death.	Do not ente	r the mode o	of dying, such es card	liac or respiratory	errest,	Approximate				
hysician	shoot or he	eart failure. List on	ly one ceuse on each	line.						Interval Bet Onset and I				
Medical	Immediete Caus	Immediate Cause (Final												
xaminer	disease or condi- resulting in death	disease or condition												
- T	Due to (or as a consequenca of):													
in and hel-trensit			b. 10S			111/0/~			70					
2 e g			Sequentially list conditions, if any, leeding to immediate											
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				Decedent's Name (First, Middle, Last	1)	(Certific	cate d	of Dea	th	2. Date of D		0	0 6 8 0	
		Physici /Medi		Amos Handy							Februa:	ry 13, 1	998	18:20	
		Examinum Funeral Director		220-26-3243	al Hospital	vrs. løst birthe Yr	Mon	nder 1 Y	Harvear If Un	ve de	(Month, D	Harfo	rd	lace (Stete or F try) .and	
		pue ***		Usual Rasidence of Decedent 10a. State 10b. County	10c.	City, Town	or Location						1	0d. Inside City	
		death with the Marylend ms 23a or 28a-f show prest be notified at	Director	Maryland Harford	Н	arve d		ace . Zip Cod	40			10g. Citizen of		1 Yes 2	
		3a or		421 So.Union Ave.	Brebin Nurs	ing Ho			1078			USA	What Cour	itry r	
	020	urs efter death	by Funeral	11. Marital Status 1 Never Married 2 M Married 3 Widowed 4 Divorced	12. Was Decedent Ever In Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		13. Was D If Yes,	ecedent specify (pecify Yes or No Ricen, etc.)	o- 14. Rac Bla Specif	ce - Americ ck, White,	etc.	
	21215-0	within 72 hourselens.	Completed	15. Decedent's Edu (Specify only highest grad Elamantary/Secondary (0-12)		life. DO NO			cupetion ona during r tired)	most of wor	kirıg	16b. Kind of Bu		usiness/Industry	
	ryland ?	hould be filed d Mentel Hyg narked other natic event, I	To Be Co	17. Father's Name (First, Middle, Last) George Hynson	and Drings				Ma	ary I	Handy	e, Maiden Sumer	ne)		
	Baltimore, Maryland 21215-0020	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examination with the notified at ance.		19a. Informant's Name/Reletionship (7) Susie Handy (wif 20a. Method of Disposition 1 Burial 2 Cremetion 3 F	Ee) Removal from State		Mass	sey A	Ave.,	Churc	ch Hill Date	Maryla 20c. Location	nd 21 City or To	.623 own, State	
Ď	Baltin	permit. Pa Departmen Important: any injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	I	osevil	22. Nam Bet	e and Ad	Smit	acility h Fund	eral Ho	Hope,Ma me ryland 2		nd	
	E	Physician Medical Examiner bubasician and physician and physician are the private at the privat	dical Examiner	23a. Part1. Enter the disease, or compishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause, (Disease or Injury	Due to		Val (cul			iden!		<	Interval Betwee Onset and Dec	
	Box 68760,	death certificate be e ettending physicia d for use as the bur	w	Cause (Disease or Injury that Initiated events resulting in daath) Last	C. Due to (or es e consequence of): d										
	Records, P.O. B	v requires thet the death certific been signed by the ettending p should be detached for use as	ted by Physician/M	Pert II. Other significant conditions con		_	_	HIP	givan In P	art t.	1 [Yes 2 No	3 Tol	bably 4 Un	
		N S S	Completed								10	Yes 2016	of	mplation of cau death? □ Yes 2□ No	
anali	on of Vital	To the Hospital or Attending Physician: The Is within 24 hours effect death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	To Be	27. Manner of Death 1 Waturel 5 Pending	Hospital: 1 The patient 28a. Date of Injury (Month, Dey Year	2 ER/Outp	ne of		Other	Nursing H		one) Idance 6 Oth		γ)	
F	Division	To the Hospital or Attending Phys within 24 hours effect death. To the Funeral Director: After this completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)									nd Number or Rural Route Number, e)		
		he Hospi in 24 hou he Funer pletely fill	edicai	29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceusa(s) and mannar as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(and menner stated).									tated. the causa(s)		
9		To the Com	Σ	29b. Signatura and title of sertifier				B.	ense numb	erci		29d. Date signe			
				30. Nama and addrass of person who co	ompleted cause of death (I	Itam 23a) (Ty	pe, Priet)		0 -	01 -11	0	0	100		



1. Decedant's Nama (First, Middla, Last)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death

Month

MD

3. Tima of Death

10d. Insida Cltv Limits

white

Approximata intarval Batween Onsef and Death

1 year

1 ☐ Yas 2 ☐ No

1998

29d. Data signed (Month, Day, Yaar)

21502

February

1 Yas aF No

5:55 pm

Physician
/Medical
Examiner

Funeral Director

with the Meryland show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at "natural",

death filed within 72 hours after Baltimore, Maryland 21215-0020 Hyglene. Pages 1 and 2 should be finent of Health and Mental Int: If Item 27 is marked of Injury or other permit. Page Department of Important: If any Injury or

Physician /Medical Examiner

attending physician and for use as the bunel-transit page 2

Box 68760, certificate be signed by the at d be detached for o 0 peed has certificate Division of Vital Attending Physician: funeral director, this After death. Hospital or Attendit 24 hours after death. Funeral Director: A à 24 hours To the Hosp within 24 hor To the Fune completely fi

217-10-4650

HORCHLER

JOHN

John H. Horchler February 16, 1998 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Cumberland Allegany If Undar 1 Yaar if Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Yaar) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Days Months M 2□ F Yrs 217-10-4650 82 Aug 3, 1915 Usual Rasidanca of Dacadent 10e Stata 10b. County 10c. City, Town or Location Director MD Allegany Cumberland 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? 933 Winifred Road 21502 USA Funerai 12. Was Dacedanf Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Yas Mo If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 🎾 No by Specify 3€ Widowad 4 Divorced Completed Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Sacondery (0-12) Collaga (1-4or 5+) Retired B&O Railroad 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Meidan Sumama) John Henry Horchler Margaret (Howarth) 19b. Meiling Addrass (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Joyce A. Rockwell-daughter 400 Wempe Drive Cumberland MD 21502 20b. Place of Disposition (Neme of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stata Restlawn Memorial Gardens 02/20 4 ☐ Donation 5 ☐ Othar (Spacify) LaVale MD 22. Nama and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signatura of Funaral Sarvica Licensee Cumberland MD 21502 23a. Party. Enfar tha disaasa, or complications that ceuse the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition rasulting in death) a Intractable CHF Due to (or as a consequence of): Examiner Sequantially list conditions, if eny, leeding to Immediate ceuse. Enter Undarlying Cause (Diseasa or injury that Initiated avants rasulting in death) Last Due to (or as a consaguance of) Physician/Medical Dua to (or as a consaquance of) Part If. Other aignificant conditions contributing to death buf not resulting in the underlying ceuse given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown by 24e. Was an autopsy performad? 24b. Wara autopsy findings availabla prior fo complation of ceusa of daath? Completed 1 Yas 25. Was case rafarrad to medical axaminer? Be 26. Placa of Death (Check only one) 2 No Hospitel: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatient 2 1 ☐ Yas 2 ER/Outpatient 3 DOA 27. Manner of Deeth Certification: 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accidant 5 Panding investigation 1 Yas 2 No 3 Sulcida 8 Could not be datarminad 28a. Place of Injury - At homa, farm, straef, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 | Homicide

12 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

The Market Examples: On the basis of examination and/or investigation in my opinion, death occurred at the time, data and place, and due to the

29c. Licansa number

D 16041

minar: On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and piece, end due to the ceuse(s)

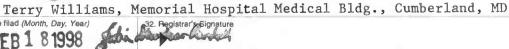
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31. Date filad (Month, Day, Year) State 8 1998 Registrar

29a. Certifier

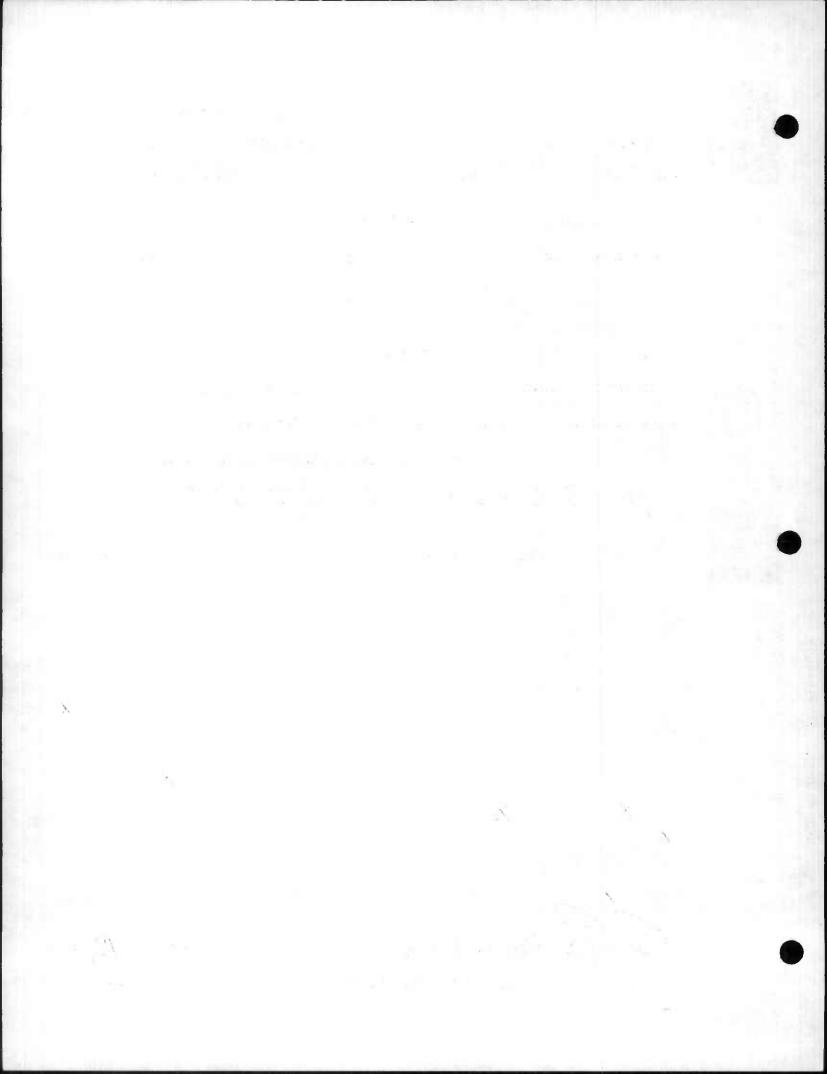
29b. Signiture and title,

Medical

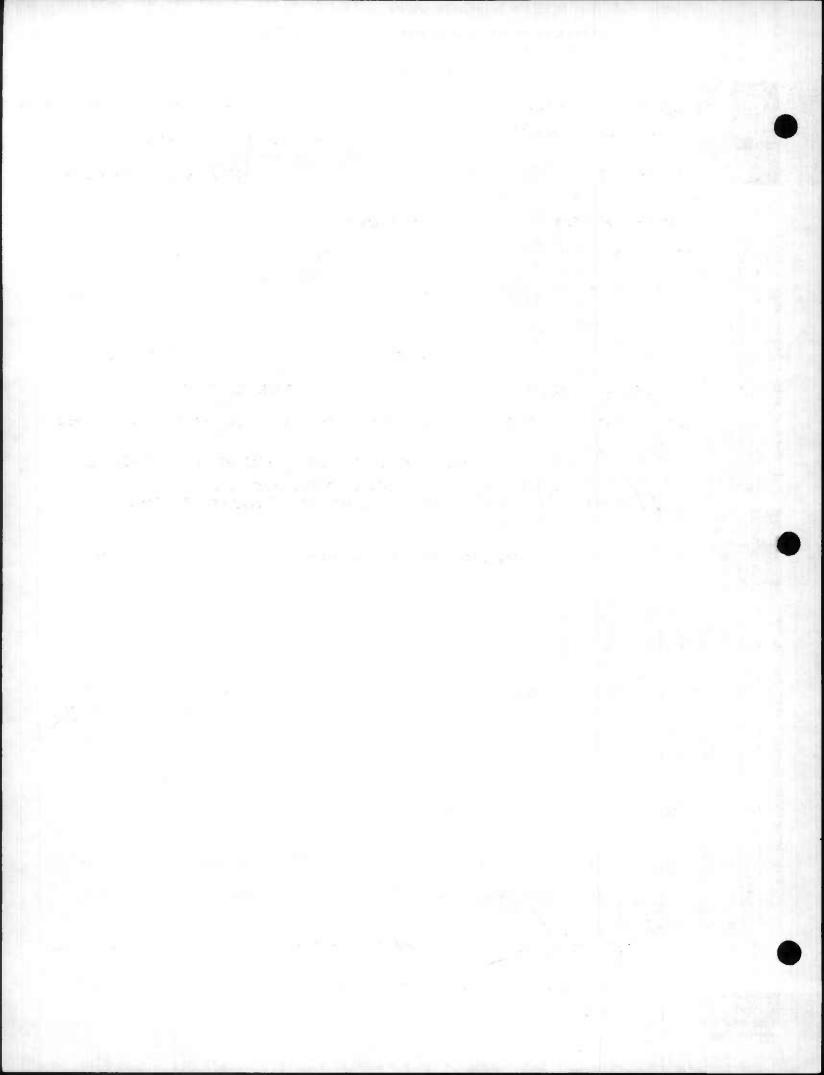


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and mannar stated.



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Funeral		5. Social Security Nu	ımber 6. S	Sax	7. Aga (In yrs	last birthday)		r 1 Yaar					-	piaca (Stata or Fora		
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a pho	_		10b. County		106. C	ity, Town or Lo	ocation						1	1 □ Yes 2√2 N		
or 28a-f show be notified at Director		MARY LAND 10e. Street and Num	ALLEGAN	<u> </u>		FROS	1	p Code			10-	0.00	10.10			
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	1	23a. Part1. Enter the shock, or heart	a disaasa, or com	plications that of	caused the dae	th Do not ant	O W.	MAII	N ST., I	ROSTBU	RG, I	MD 215	32	Approximate interval Batwaan		
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100		thet initieted avants resulting in death) Le		d	Dua to (d	or es e conseq	uance of)	•								
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atached		Part Ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i.							23b.	Did tobacco use contribute to the cause of desti						
2 should										24a. Was an autopsy performed? 24b. Wara autopsy find eveilable prior to completion of caus of desth?						
paga 2 Comp	3										1□ Yas	2 No	10	□Yas 2□ No		
rector, p)	25. Was casa rafarra axaminer?	id to madical		1	,				Daath (Check o	only one)					
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ation		27. Manner of Daath Natural 2 Accident	5 Panding invastigation	1	of injury th, Day Year)	28b. Tima of Injury	М	28c. inju Wo 1 □			ribe how	now injury occurred				
led In by the funera Certification:		3 ☐ Suicida 4 ☐ Homicide 6 ☐ Could not be datarmined 28a. Piece of Injury - At home, ferm, straat, factory, office building, atc. (Specify)								28f. Locat City o	lon (Street Town, S	et end Numb Stata)	er or Rura	al Routa Number,		
completely filled In by the Medical Certific		29a. Certifier (Check contains)	Certifying Ph	niner: On the b	best of my kno asis of axemina nar stated.	wledge, deeth	occurred vastigation	at the ti	ime, dete end ple opinion, death o	ece, end dua to courred at tha t	the ceus ima, data	se(s) end me and place, a	nner as s	teted. tha ceusa(s)		
compla Med		29b. Signature and ti	the of certifiar	//					sa number		29d.	. Data signed	(Month,	Day, Year)		
		M	214	-	DI	oty Med	Ex	D 0	9157		F	'EBRUAI	RY 10	, 1998		
,		30. Name and addires	ss of person who	complated caus	sa of daath (ital	m 23a) (Type,	Print)	- 8								
4			Sno, M.D				Md 2	1502								
		 Dete filed (Month) 	, Day, Year)	1 . A32. F	registrar's Sign	ature										



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Honth February 21 ... Dev **Physician** JAMES 1035 1998 Domas /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 05-1-1913 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Deys Hours Min. 1XM 2 F MD 218 - 20 - 68 4 2 Usuel Residence of Decedent Yrs. Director 10a. Stete 19c. City, Town or Location 10d. Inside City Limits 7 is marked other than "nature!", or itema 23a or 28a-f ehow traumatic event, fine Modical Examinar must be notified at MD 1 Yes 2 No Director Jom c15ct the 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Numbe 501 FEN Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 DNo If Yes, Give Yeer or Detes: 14. Rece - American Indien Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Merried altimore, Maryland 21215-0020 Black 1 Yes 2 No Specify: g 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) meiset should be filed within Elementery/Secondery (0-12) College (1-4or 5+) 218-20-6842 sould of Educa 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be h end Mental h STEVENSON Estella ARENCE 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Princess Anne W: f Civele TENIOR MD Department of Health 501 other t scralding 20b. Place of Disposition (Name of cometery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition Wesely Cemera.
Wesely Cemera.

22. Name and Address of Fecility
Anthony E. Ward Fu

30639 Hampden Ave

and dying, such es cardiec or rer 1 ⊠Buriel 2 □ Cremetion 3 □ Removel from State any Injury or o 2-25-98 Westovor John 4 ☐ Donetion 5 ☐ Other (Specify) Funcial Home MD 21853 23a. Pert1. Enter the disease, of shock, or heert failure. List e death. Do not enter the mode of dying, such es cardiec or respiretory errest, Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) 42000 Examiner Due to (or as e consequenca of) Examiner ician end burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the Due to (or es e consequence of): USB BS 23b. Did tobacco usa contributa to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yss 2 No 3 Probably 4 Unknown ğ 2 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? should Completed page 2 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical exeminer? or Attending Physician: funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 28b. Time of 1 Neturel 5 Pending 1 Yes 2 No 24 hours efter death. Funeral Director: A investigetion 2 Accident Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office bullding, etc. (Specify) 4 Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner as steted. Medical 29a. Certifie 2 Madical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) Within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartifie 6 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) line 90

32. Registrat's Signeture

Jeli Studen Radell

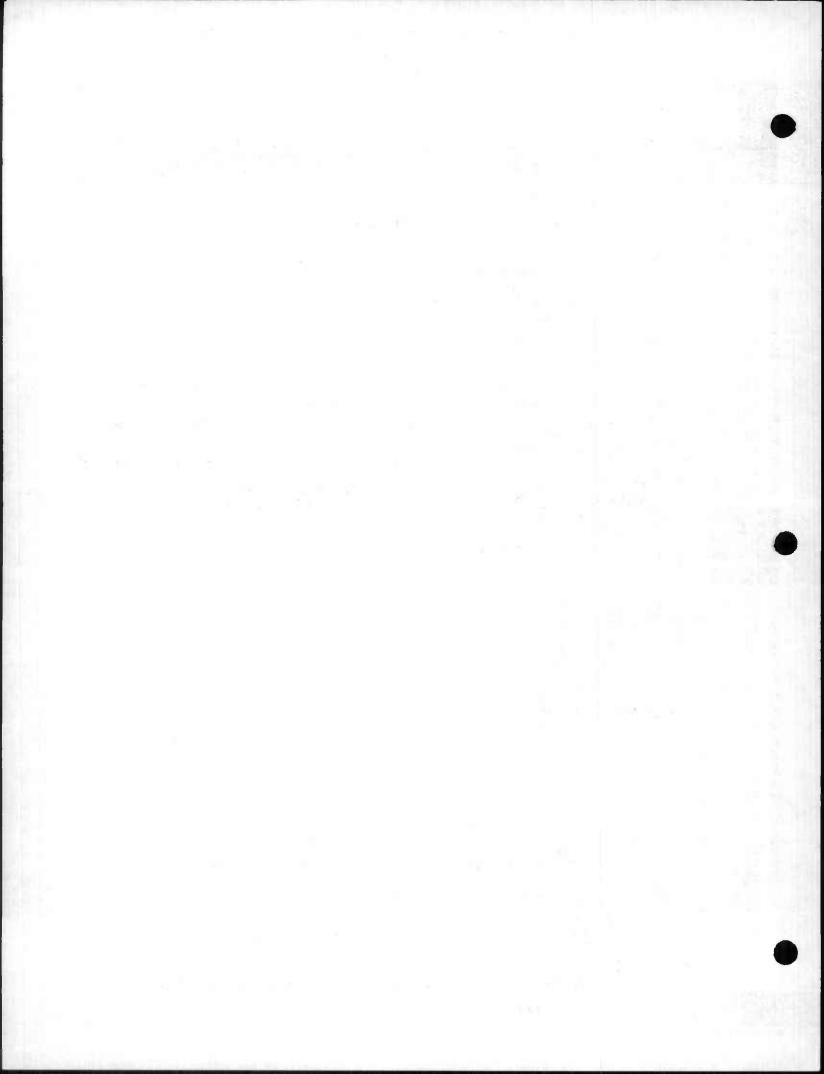
Registrar **DHMH 16 Rav 6/95**

31. Dete filed (Month, Dey, Year)

FEB 25

1998

Physici /Medic Examir Funeral Director	cal	1. Decedent's Name	(First, Middle, Las								46		0.71
Examir Funeral Director			Emery	ISALY	Sr.					2. Date of De Month Februa	Day	Year 1998	3. Time of Death 10:00 p.1
D .	ier	4a. Fecility Name (If If Garrett C 5. Social Security Nur 202–26–27 Usual Residence of E	County Me mber 6. S	morial			If Under 1 Year Months Days	If Unde	Oakla or 24 Hrs.	8. Date of Bi	rth ay, Year)	Garre 9. Birthp Coun Penns	
a la			10b. County		10c. City,	Town or Loc	cation					1	0d. Inside City Limits
a-f sh	ctor	MD	Garre	tt					N	1cHenry			1 ☐ Yes 2 🎇 No
Vitra un	Funeral Director	10e. Street end Numb					10f. Zip Coda				10g. Citizen o	f Whet Coun	ntry?
23e	erai	1906 Moss	er Road	12 Was Daca	dent Ever In U.S	12 V	Vas Decedent of	21541		asify Vac or Ne		USA ace - Americ	an fodian
al', or iten	by	1 Never Merried 3 Widowed 4		Armed For 1 Tyes If Yes, Give Year or Da	ces? 2 □ No	If	Yes, specify Cut	oan, Mexic	an, Puerto	Rican, etc.)		ack, White,	
s should be med within 7.2 hours arise death with the Meryand s marked other than "natural", or items 23a or 28a-f show sumatic event, the Medical Examiner must be notified at	Completed	(Specify	15. Decedent's Ed y only highest grad dary (0-12)	de completed) Collaga (1-		(Give I life. D	ent's Usual Occu kind of work done O NOT use retire	during mo	ost of work	ing	16b. Kind of	Business/inc	dustry
Hygie ther ti	CO	17. Father's Neme (F	irst, Middle, Last)	2		Off	ice Man		har's Nam	a (First Middle	Dairy , Maidan Suma	Store	es
0 = 0 5	To Be	Henry		Isal	v			Lou				Emery	
permit. Deperment of Health and Menta Important: If item 27 is marked eny Injury or other traumatic ev		19a. Informant's Nam	ne/Ralationship (7			19b. Mailin	g Address (Stree			al Route Numb			Code)
m 27 in		J. Ealine		ife			Mosser l	Road,	МсНе				
or of			Cremation 3			netery, crem	ition (Name of atory or other pla	ice)		Date	20c. Location	- City or To	wn, State
ortant Injury		4 ☐ Donation 5 21. Signeture of Fund	Other (Specify		Ome		matory Name and Addr	ess of Eaci		2/20/98	Morgan	town,	WV
Deperment of the poor of the p		D Q	W N 1	0		S	tewart 1	Funer	al Ho				
		23a. Part1. Enter the shock, or heart	disease, or comp	licetions thet ca	used the death.	Do not ente	2 S. Sed	cond ing, such a	St.,	oaklan	d, MD	21550	Approximete
hysician /Medical xaminer		Immediete Cause (Fi			emic hea							y	Interval Between Onaet and Death 'ears
	2	resulting in death)			Dua to (or	as a consequ	Janca of):					i	
e ettending physician end od for use es the bunel-transit	Medical Examiner	Sequantially list cond if eny, leeding to imm causa. Enter Underly Causa (Disase or in that initiated events resulting in death) La		c	Dua to (or	coron as a consequ as e consequ		ery by	ypass	graft		1	2 years
ettending for use as	clan/			a								1	
by the	Physician/M	Part II. Other signification high block			ath but not result	ing in the un	derlying causa gi	ven in Parl	t I.		tobacco uae c Yes 2□ No		the cause of death
igned t	by P	might bio	- Pressi	ire							100 1010	-,	ALDIY GOTINION
peen s	Completed	hyperlipi	idemia								an autopsy ormed?	ave	era autopsy findings eilable prior to mpletion of cause daath?
(9	Con									10	Yes 2 No	1 🗆	Yes 2□ No
r this certificate	Be	25. Was case referred examiner?	111111111111111111111111111111111111111	Hospital:			_ 01	hor		h (Check only	-		
19 a	ition: To	1 Inpatient 2 MEH/Outpatient 3 IDOA 4 Invirsing									dence 6 00 how injury occu		1)
s efter death.	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be detarmined	28e. Place of building	of Injury - At hom g, etc. (Specify)	ne, farm, stre	et, factory, office			28f. Location (City or To	Street and Nun wn, State)	nber or Rura	l Routa Number,
within 24 hours efter To the Funeral Dire completely filled in b	edical	29a. Cartifier 1 (Check only 2 one)	Certifying Phy Medical Exam	sicfan: To the base	sis of examinetic	adga, death on end/or Inve	occurred at the ti estigation, in my	ma, data a opinion, de	nd placa, eath occurr	and due to the ed at the lime,	causa(s) and n date and place	nannar as st , and due to	ated. the cause(s)
withi To th	×	29b. Signature and ti	leyot defetier				29c. Licens	se number	777		29d. Date sign	ed (Month, I	Dey, Year)
		1	11					(5)	555		211	8/90	
\\	11/2	30. Name and add as					•				1		
Sta	17	Thomas G 31. Date filed (Month,			311 N girnar's Signatu		th Stree	et O	aklan	d, MD	21550		



	-		1 Decedent's Name /First Middle 1	State of M	arylanu		ertifica				Reg. No.	3 01	5809
	Physici /Medi	cal	Decedant's Nama (First, Middla, L Katherine Jo 4a. Fscility Name (if not institution, g.)	ones-Thomas	3				4b City Town	2. Data of D Month PC D or Location of Dea	Day 15 10	Year 298	3. Tima of Death
	Examir Funeral Director	ner	For t Washir 5. Social Security Number 6. 579–66–5439	orton 7. Ag	HOS Page (In yrs. la:	>i \C	Months	r 1 Year		rs. 8. Data of B	on Pric	10e (ce (State or Foreign
ī	ahow ed.et		Usual Rasidance of Decedent 10a. Stata 10b. County		10c. City,	Town o	r Location					100	d. Insida City Limits
	the Maryland 28a-f show notified at	Director	MD P.O	· ·	Te	mp1	e Hill	S					1 Yes 2 □ No
	Mith the Age of 2	Dire	10e. Straat and Number				10f. Z	p Code	2740		10g. Citizan of N		
020	n 72 hours after death with the Maryla "natural", or literne 23s or 28s-f athor edical Examiner must be notified at	by Funeral	3342 Huntley Squ 11. Marital Status 1 Never Merried 2 Marriad 3 Widowed 4 Divorced	12. Was Decedant Armed Forces? 1	Evar in U,S		13. Was Dece if Yas, spe 1 \(\sum \) Yas	edent of H	0748 tispento Origin? an, Mexican, Pur Specity:	(Specify Yes or N erto Rican, etc.)	United	e - Amaricar ck, White, et	n Indian, c.
21215-0020	With the Man	Completed	15. Decedent's E (Specify only highast g Elementery/Secondary (0-12) 10th	ducation		16a. De (C	e. DO NOT	use <i>retire</i> d	ation during most of w d)		16b. Kind of B	usinass/indu	stry
	office Try	Be C	17. Father's Nama (First, Middla, Las	t)			1100	ICUI		ama (First, Middle			
Maryland	should be nd Mental marked o	TOE	Quince Sinclair							tie Johr			
Mag	D 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		19a. Informent's Neme/Ralationship							Rural Routa Numi			
_	ges 1 and if of Health if hem 27 or other tr		Everett Thomas - 20a. Mathod of Disposition	Husband	20b. Ple	ce of D	42 Hun isposition (Na crematory or	tley	Square	Dr., Ten	101e Hil. 20c. Location -		
E C	8025		1 Burial 2 Cramation 3 days at 2 Donation 5 Othar (Spec				ny Memory or			1/21/98	Lande	over,	MD.
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatura of Funaral Sarvice Lice				22. Neme e R. N.	nd Addre	ss of Fecility	Morticia et, N.W.,	ns, Inc		
\ \	Physician		23a. Pert1. Entar the diseasa, or cor shock, or heart fallura. List only	nplications that caused one causa on each ii	the deeth. na.	Do not	antar the mo	da of dyir	ng, such as card	lec or respiretory	errest,		Approximata Interval Between Onset and Death
	/Medical Examiner		immediate Cause (Final disease or condition rasulting in death)	a. End	STag Due to or s	s e cor	7 Ve / I	an	(land	es		le	Know
	uted 1 ansit	Examiner					IPU7	ins	ion			u	Know
8760,	icate be executed physician and s the burial-transit	edical Exa	Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Csusa (Disease or Injury that initiated events rasulting in death) Last	C	·		sequence of)						
Box		-		d								i	
	e death	Physician/M	Part II. Other algolificant conditions	contributing to death b	ut not result	ing in th	e underlying	ceusa giv	ran in Part I.	23b. Dic	tobacco use co	ntribute to t	he cause of death?
s, P.O	res that the de signed by the a be detached t	by Phy								1	Yes 2□ No	3 Proba	bly 4 doknown
Records,	aw requi	Completed b								24a. Wa	s an autopsy ormed?	avail	a autopsy findings able prior to pletion of cause eath?
	The ate h	Con								1 🗆	Yes 2 No	10	Yas 2□ No
<u>=</u>	certificate rector, pay	Be C	25. Was casa refarred to medical axaminar?	Hospital:				OA Oth	ar:	eath (Check only			
Division of Vital	g Ph serth	ition: To	1 Yas 2 No 27. Manner of Death 1 Naturel 5 Panding 2 Accident invastigation	28a. Data of Inju (Month, Da	ry 2	R/Outpa 8b. Tim Inju	e of my M	28c. Injur Wor	4 LI NUISING	Home 5 Res	how injury occur		
Divis	To the Hospital or Attending Phy within 24 hours after death. the Euneral Director: After this completely filled in by the funeral	Certification:	3 Suicide 6 Could not datarmined		ury - At hom c. (Specify)	a, ferm	, streat, facto	ry, office			(Straat snd Numb iwn, Stata)	per or Rural I	Routa Number,
	ne Hospitu n 24 hours ne Funers pletely fille	edical (29e. Certifier (Check only one) 12 Certifying P	nysician: To the best of miner: On the basis of and mannar sta	axaminetio	edga, d n and/o	eath occurred r investigation	at tha tir	na, dsta and pla pinion, daath oc	ce, snd dua to the curred at tha tima	causa(s) and ma , data and place,	annar as stsi and dua to t	ted. he cause(s)
	To the To the Com	Σ	29b. Signatura and titla of certifiar	. /			29	c. Licens	e number		29d. Dete signe		ay, Year)
	1			Jordan		,	5	04	54		Feb,	161	1998
			30. Nama and eddrass of person wife					0 0	E C	to 202	Machine	hom T	20022
	Sta Registr		Dr. Arastoo Yazo 31. Data filed (Month, Day, Year) FEB 18 19	32 Aggistr	South			e, S	·E·, Su:	ice ZUZ,	wasning	con, I	20032

DHMH 16 Rsv 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death February 16, 1998 10:50 AM Donald Mason Jones 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig Country) July 15, 1902 Massachusetts 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 ☐ F Yrs. 95 216-44-9347 Usuat Residence of Decedent 10c. City, Town or Location 10d. Insida City Limits 10b. County 1 ☐ Yas 2 ■ No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20850 United States 878 College Park Way #302 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 11. Marital Status 1 Yas 2 No If Yes, Giva Yaar or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Public Works 3 Administrator 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Dorothy Dodge William Frederick Jones 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)

878 College Park Way #302, Rockville, MD 20850

22955 Hollywood Road, Leonardtown,

Brinsfield Funeral Home, P.A.

Data

Physician /Medical Examiner

ettending physician end for use as the buriel-tran-

ed by the detached signed by

certificate hes

uneral

in by

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certific

by

Completed

Be 1º

requires that the death certificate be execu

Box 68760,

P.O.

Division of Vital Records,

permit. Pages 1 and 2 sh Department of Heelth end Important: if item 27 is m

8

any injury o

Physician

/Medical

Examiner

10a. State

Directo

Funeral

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Completed

Funeral

Director

with the Meryland

s 1 and 2 should be filed within 72 hours effer deeth with the Merylan of Heelth and Mental Hygiene. Itam 27 is marked other than "natural", or itams 23a or 28a-f ahow other traumatic evant, the Medical Evant set must be notified at

altimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Physician/Medicai

Immediata Causa (Final disease or condition resulting in death)

Barbara Durham.

4 ☐ Donation 5 ☐ Other (Specify)

1 Burial 2 Cramation 3 Removal from State

Edward N. Brinsheld,

20a, Method of Disposition

Daughter

Jr.M00052

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each lina.

а	Venticelas Febrillating
b.	Due to (or as a consequence of): Wednesday
0. —	Due to (or as a consaquence of):
C	Dua to (or as a consequence of):

22. Name and Addrass of Facility

20b. Place of Disposition (Nama of cemetery, crematory or other place)

Joy Chapel Cemetery

	d						
Part tt. Other aignificant conditions o	ontributing to death but not re	sulting in the underlyin	g caus	e given in Part I.	23b. Did tobac	co uae co 2 No	ntribute to the cause of death? 3 Probably 4 Unknown
					24a. Was an au performed	? ` *	24b. Were autopsy tindings available prior to completion of cause of death?
25. Was casa ratarred to medical				26 Place of Do	1 ☐ Yes	2 No	1 Yes 2 No
axaminar?	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐	DOA	Other: 4 Nursing		6 □Oth	nar (Specify)
27. Mannar of Death 1 Natural 5 Pending 2 Accidant invastigation	28a. Date ot Injury (Month, Day Year)	28b. Time ot Injury M	28c.	Injury at Work? 1 Yes 2 No	28d. Describe how in	njury occur	red
3 Sulcide 6 Could not be datermined	28e. Place of Injury - At I building, etc. (Spec	home, farm, street, fac	tory, of	fice	28f. Location (Street City or Town, St		ber or Rural Roule Number,
	ysician: To the best of my kn niner: On the basis ot axamin						

To the Hospital within 24 hours e To the Funeral C completely

29b. Signatura and title of certifier 29c. Licanse number 29d. Data signad (Month, Day, Year)

20c. Location - City or Town, State

MD 20650

Approximate Intervat Between Onsat and Death

2 Mu

2/21/98 Hollywood, Maryland

30. Name and addrass person who complated causa ot daath (Itam 23a) (Type, Print) John Fenwick, M.D.

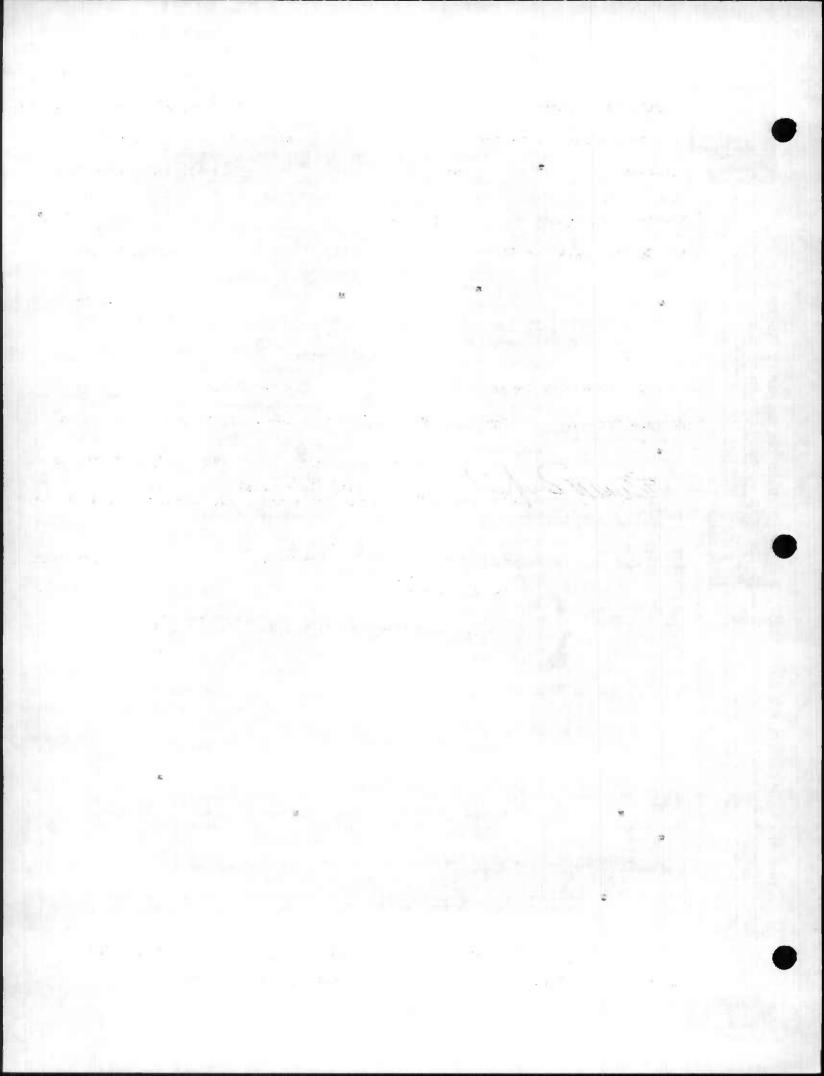
FEB 20 1998

Leonardtown, Maryland 20650

Registrar

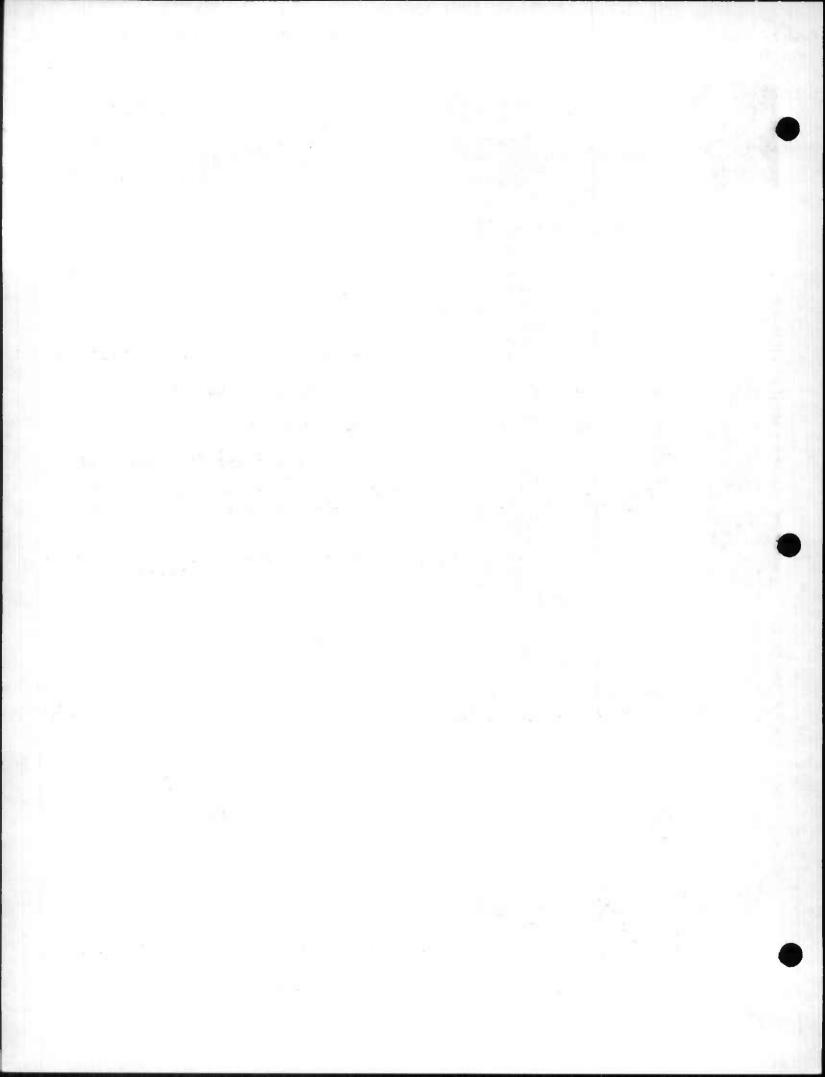
31. Date tiled (Month, Day, Year)

32. Registrar's Signature John Davidson Rardall



		State of Maryland / Department of Health and M Certificate of Death		Reg. No.	06811
		1. Decedent's Name (First, Middle, Last)	2. Date of De Month		3. Time f to th
Physic /Medi		EDWARD J. JACKSON	FEB	Day Ye	
Exami		4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Lo			
		84 LA VALE COURT LA VALE	7	ALLE	CANV
Funerai		5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Yeer if Under 24 Hrs.	8 Date of Rin		Birthplace (State or Foreign Country)
Director		216-22-6377 1 TXM 2 F 71 Yrs. Months Days Hours Min.	(Month, Da	1.1926	MARYLAND
		Usual Residence of Decedent	1100 1	1,1729	THE LETTER D
show		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Mar Fled	to	MARYLAND ALLEGANY LA VALE			1 □XYes 2 □ No
28 r	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	t Country?
3a o		84 La VALE COURT 21502	24	USA	
within 72 hours after death with the Maryland ene. then "netural", or items 23s or 28s-f show he Modical Exstrictional be rictified at	Funeral		cify Yes or No		American Indian,
Her	Fu	Armed Forces? If Yes, specify Cuben, Mexican, Puero I	Ricen, etc.)	Black, \	White, etc.
rs a	by	3 Widowed 4 Diversed if Yes, Give 1940 1 1 Yes 2X No Specify:		Specify:	WHITE
72 hours "natural",	Pa	15. Decedant's Education 18a. Decedent's Usual Occupation		16b. Kind of Busin	
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	E	Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 3 VICE PRESIDENT		OHEEN	CITY ELECTI
H P P		17. Fether's Name (First, Middle, Last) 18. Mother's Name	(First, Middle		CITI ELECT
S d ab S	Be C	The last of the la			
d 2 should th end Men 7 is marke trsumatic	To	JOHN JACKSON ALICE N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			to Zin Code)
Heel Heel		JOAN JACKSON WIFE 84 LA VALE COURT, I 20a. Method of Disposition 20b. Place of Disposition (Name of			
Pages nent of It		Murial 2 Cremetion 2 Democratifrom State cemetery, crematory or other place)	Date E B	20c. Location - Cit	
Pa men ant:		4 □ Donation 5 □ Other (Specify) ST. MICHAEL CATHOLIC	EMETE	RY FROS	TBURG, MD
permit. Pages 'Depertment of Himportant: If ite any injury or ot once.		21. Suprature of Funeral Servica Licensea 22. Name and Address of Facility			
20 5 5 8		HAFER CHAPEL OF	THE H	ILLS MO	RTUARY
_		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or shock, or heart failure. List only one cause on each line.	Y, LA	VALE, M	D 21502 Approximate
Physician		shock, or heart failure. List only one cause on each line.			Onset and Death
/Medical		Immediate Cause (Final			UNKNOWN
Examiner		disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCUI	JAR HE	DISEAS	YEARS
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uted	Examiner	Sequentially list conditions. Due to (or as a consequence of):			
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eeth certific ettending p i for use es	Physician/Me	d			
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by the detected	ıysı	Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i.			bute to the cause of death
thet det		NORMOPRESSURE HYDROCEPHALUS 2 YEARS	1 0	Yes 2□ No 3	Probably 45 Unknow
Se ig	d by		24a Mas	an autopsy 2	4b. Were autopsy findings
been s	ete		perfo	ormed?	available prior to completion of cause
2 8 8	Completed				of death?
Pa at	S		10	Yes 2 No	1 ☐ Yes 2 ☐ No
certificate rector, pag	Be	25. Was cese referred to medical Agaminer?	(Check only	one)	
5 00	ဥ	1/2 Yas 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	ne 5 Resi	dance 8 Othar	Specify)
			28d. Describe	how injury occurred	
Attending or death. ector: After by the fune	atic	2 Accident Investigation M 1 Yes 2 No			
Atte	tifle	3 ☐ Suicide 4 ☐ Homicida 6 ☐ Could not be datarmined 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)	28f. Location (Street and Number	or Rural Route Number,
s efter	Certification:	outlang, etc. (opecary)	ony or vo	, otalay	
Hospital 24 hours Funeral stely filled		29a. Cartifier 1 Certifying Phyaician: To tha best of my knowledge, death occurred at the time, date and place, a	and due to the	ceuse(s) and mann	er as stated.
P Ho P Fu Petel	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred and manner stated.	ed at tha time,	data and place, and	dua to the cause(s)
To the Hospital or Attand within 24 hours efter death To the Funeral Director: completely filled in by the	Me	29g/ Signature and title of certifier 29c. License number		29d. Dete signed (f	Month, Day, Yaar)
21		DPTY MED EX D 09157		FFRRIIAD	Y 14,1998
Se /		per gran		TIDIOUL	1 17,1770
nes		10. Name and address of person who complated cause of death (item 23a) (Type, Print)		W 0.5	
		PAUL SNOW, M.D. 124 3RD STREET, CUMBERLAND, 131. Date filed (Month, Day, Year) 32. Registrar's Signature	MD 21	502	
Sta Registr		di Mari			
Registi	ar	EED 1 81008 Sala delle minerie			

DHMH 16 Rev 6/95

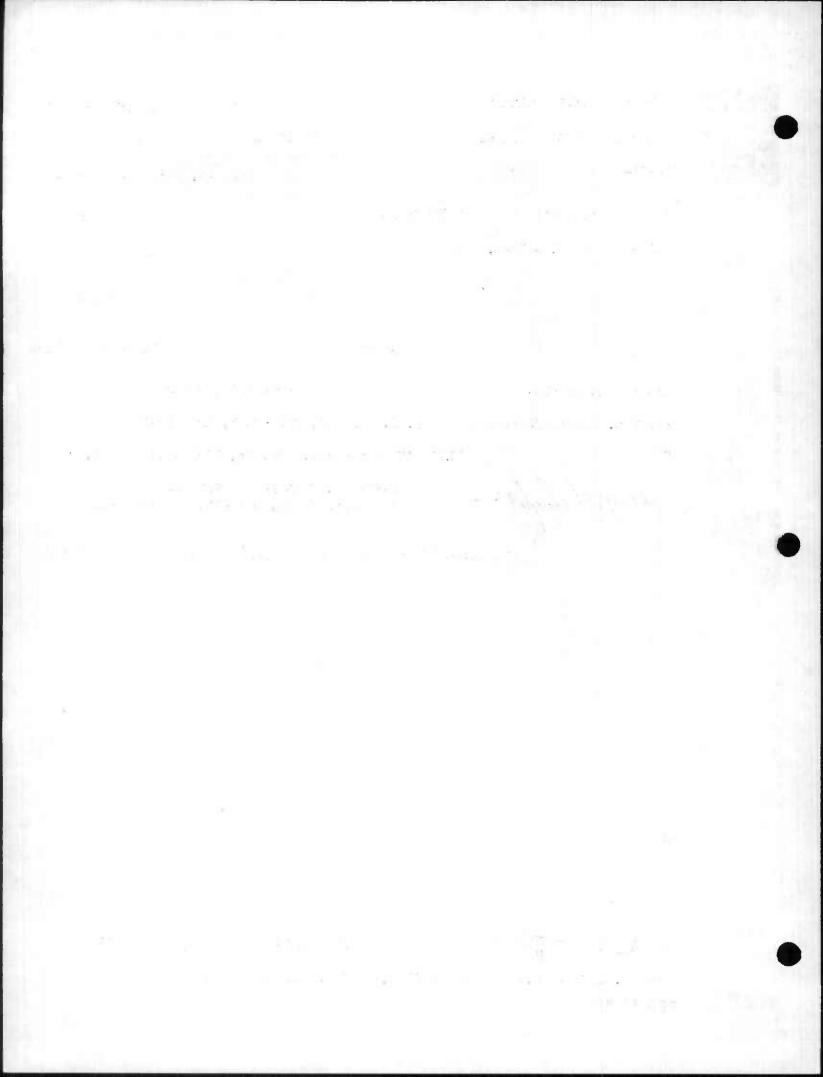


State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 1. Decedant'a Nama (First, Middle, Last) 2. Dete of Daeth 3. Tima of Deeth 24, 1998 **Physician** DELLA MARY KIMMEL FEBRUARY 7:30 am /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 10203 GREENWOOD STREET ELLERSLIE ALLEGANY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1□M 2XF 87 214-07-5074 Yrs. Director SEPT 19, 1910 PENNSYLVANIA Usual Rasidanca of Decedant deeth with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD ALLEGANY ELLERSLIE 1 X Yas 2 No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizan of What Country? 10203 GREENWOOD STREET, P O BOX 41 21529 USA by Funeral 12. Was Decedent Evar In U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, White, atc. Pages 1 and 2 should be filed within 72 hours efter nent of Heelth and Mentel Hygiene. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) LABORER TEXTILE MANUFACTURING 8 7 is marked other traumetic event. 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be LEE REUBEN STOLLAR GOLDIE MARIE NELSON 19a. Informant's Name/Ralationship (Type, Print) 19b. Meilling Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) or other tra LEROY C. KENNELL/CAREGIVER P. O. BOX 244, ELLERSLIE, MD 21529 20b. Placa of Disposition (Nama of cametary, cramatory or other p 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from State Depertment of Important: If any injury or once. WEST FINLEY CEMETERY FEB 28, 1998 WEST FINLEY, PA 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvica kicanses 22. Nama and Addrass of Facility HARVEY H. ZEIGLER FUNERAL HOME lease, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiretory errest, ure. List only one cause on each line. 15545-0636 Approximata Intervel Between Onsat and Death **Physician** /Medical Immediata Ceusa (Final CORONARY DISEASE 198 ARTERY disaase or condition rasulting in death) Examiner Dua to (or as a consequenca of): Examiner The law requires that the death certificate be executed buriel-trensit Sequantially list conditions, if any, leading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury that initiated avents rasulting in death) Lest Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical the Dua to (or as a consaguanca of) 950 ate hes been signed by the etter pege 2 should be deteched for Part It. Other algnificant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wera autopsy findings evallable prior to 24a. Was an eutopsy performed? Completed completion of causa of death? 1 Yas 2X No 1 ☐ Yas 2 ☐ No certificate or Attending Physicien: director, Be 25. Was casa rafarred to medical 26. Placa of Daath (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Othar: 4☐ Nursing Homa 5X Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No Certification: To this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After 1 Natural 5 Panding s efter death. 1 ☐ Yas 2 ☐ No invastigation 2 Accident the 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, straat, factory, office building, alc. (Specify) filled in by 4 - Homicide within 24 hours a
To the Funeral D
completely filled Hospital 10 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifie Medical To the 29b. Signature and tith of certifier 29c. Licensa number 29d. Date signad (Month, Day, Year) MD FEB 24,98 023371 10 30. Nama and address of parson who completed cause of daath (Itam 23a) (Type, Print)
QAMAR U. ZAMAN, MD., 625 KENT AVENUE, CUMBERLAND, MD 21502 15th 1998 par) Julia de liberto signature

DHMH 16 Rev 6/95

State Registrar



		1. Decedant's Nan	na (First, Middla,	Last)					2. Data of D	Reg. No.		3. Tima of Deatl	
hysic									Month	Day	Year		
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Exami	ner	200								To. County	OI DOGIII		
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D A	Be			·				io. Mothers Ne	ine (rirst, Middle	a, Maldan Sumam	a <i>)</i>		
is marked of sumatic eve	10		es M. G			19b. Mailing Addra		Emma	E. (Twice	jg)			
7 is marke traumatic		19a. Informant's N		p (Type, Print) - DAUGHTER		19b. Mailing Addr.	ass <i>(Streat at</i>	nd Number or F Δ \/ F	lu <i>ral Flou</i> ta Numī CIMPEDI	AND, MD.	State, Zip C	oda)	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEB 21 1998 VAIIDA LUCINDA KIRBY 8:00PM /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 53 FROST VILLAGE FROSTBURG ALLEGANY 5. Social Security Numbe 215-05-6343 If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Dey, Birthpiece (State or Foreign Country)
 Maryland **Funeral** Days Hours 1 M 2 KF 87 Yes Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 ie marked other than "naturaf", or items 23a or 28a-f shov traumatic event, tra Mourcal Examiner must be notified at Maryland Allegany Frostburg 1 ☐¥es 2 ☐ No Director 10e. Street and Number 53 Meshach Frost Village 10f. Zip Code 10g. Citizen of Whet Country? 21532-U.S.A. permit. Peges 1 and 2 should be filed within 72 hours after death v. Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "natural", or items 22 any injury or other traumatic excess. Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: White à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 Coilege (1-4or 5+) Elementary/Secondary (0-12) Beautician/Owner Hairdresser Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be George M. Brown Annie E. Harvey 2 19e. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Rosalile Jones Niece 8407 Norwood Drive Millersville Maryland 21108-Baltimore, 20e. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete Mount Savage Methodist Cemet 25-Feb-98 4 ☐ Donetion 5 ☐ Other (Specify) Mount Savage, Maryland 21. Signature of Funeral Service Licena 22. Name and Address of Facility n Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. P.m.1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, hock, or heart failure. List only one ceuse on each line. Approximete interval Between Onset end Death **Physician** /Medical immediate Cause (Final disease or condition resulting In deeth) CARDIAC ARRYTHEMIA SUDDEN Examiner ARTERIOSCLEROTIC HEART DISEASE UK YRS Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and burial-tran Due to (or as a consequence of) physician the burial Box 68760, Physician/Medical Due to (or as e consequence of): ed by the attending detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by I 2∏ No 3 □ Probably 4 □ Unknown Yes SENILE DEMENTIA; LEFT LOWER LUNG CONSOLIDATION by NICOTINE ABUSE 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed peen this cartificata has page 2 1 ☐ Yes 2 ☐ No 1 Yes I or Attending Physician: after death. Director: After this cartifica 25. Was cese referred to medicel examiner?
Yes 2 No Be 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home P Residence 6 Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) funeral 27. Menner of Death 28c. injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) completaly filled in by 4 Homicide To the Hospital c within 24 hours af To the Funeral Di 29a. Certifier Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner as stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manyer stated. 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) DPTY MED EX D 09157 FEB 21 1998 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print)
124 W 3RD ST CUMB MD 21502 PAUL SNOW, M.D. 31. Date filed (Month, Day, Year) FEB 3 4 199 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

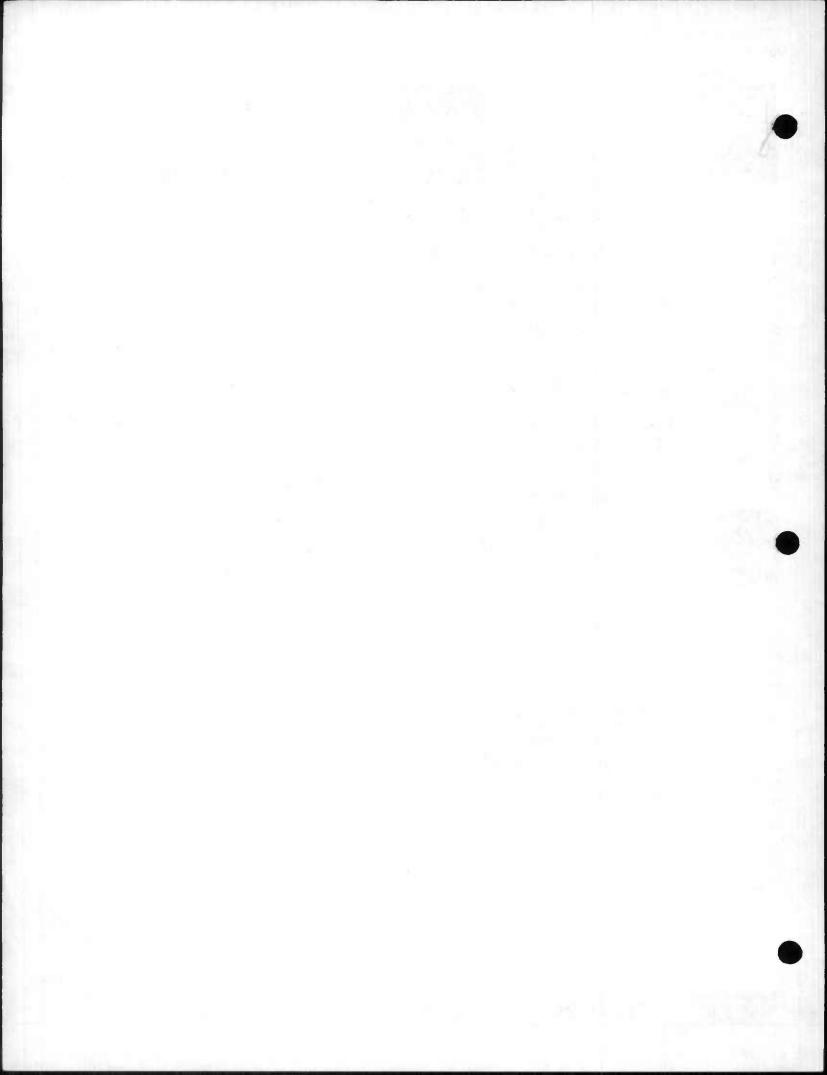
Alegany Alegany

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 6:35 Am February 1998 22 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Columbia Lorien Nursing Home Howard If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 1□M 2 F 213-22-3850 93 Yrs Director Oct. 25, 1904 Maryland Usual Residence of Decedent with the Meryland 10e Stete 10b. County 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Exposiner near be notified at Howard Maryland Columbia 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Diamond back Drive 9425 USA 21045 permit. Peges 1 end 2 should be filed within 72 hours efter death v Department of Health end Mental Hygiene. Important: if Item 27 is merked other than "natural, or items 23a any Injury or other traumatic event, the Medical Examples invest of 20ncs. Funeral 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 M No þ Specify: white 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Dry cleaning clark 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be KeilING Dudley John Isabella P 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) Paul F, KeiFer 9425 Diamond back pr. columbia, Md. 21645 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 State 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) 25, 1998 Cumberlowd, md. Sunsot Mam, Park 21. Signature of Funeral Service Licensee 22. Name and Address of Feelility Fuweral Home 230 Baltimore a, Riley, In Ernest Ave, cumberland, md. 21502 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final BRONCHOPNEURONIA one beek disease or condition resulting In death) Examiner Due to (or es e consequence of). Physician/Medical Examiner physician end the buriel-trensit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Records, P.O. Box 68760 Due to (or as e consequence of): 98 9SD ŏ signed by the a d be detached f Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? HUPERTENSION 1 Yes 2 No 3 Probably 4 Unknown þ ostes authoritis 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed multiple Decubiti 2 No 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Menper of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b Time of 28c. Injury et Work? After 1 Neturel 5 Pending Mig 10 1 Yes 2 No 24 hours efter death. Funeral Director: A investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stefe) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide WA. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

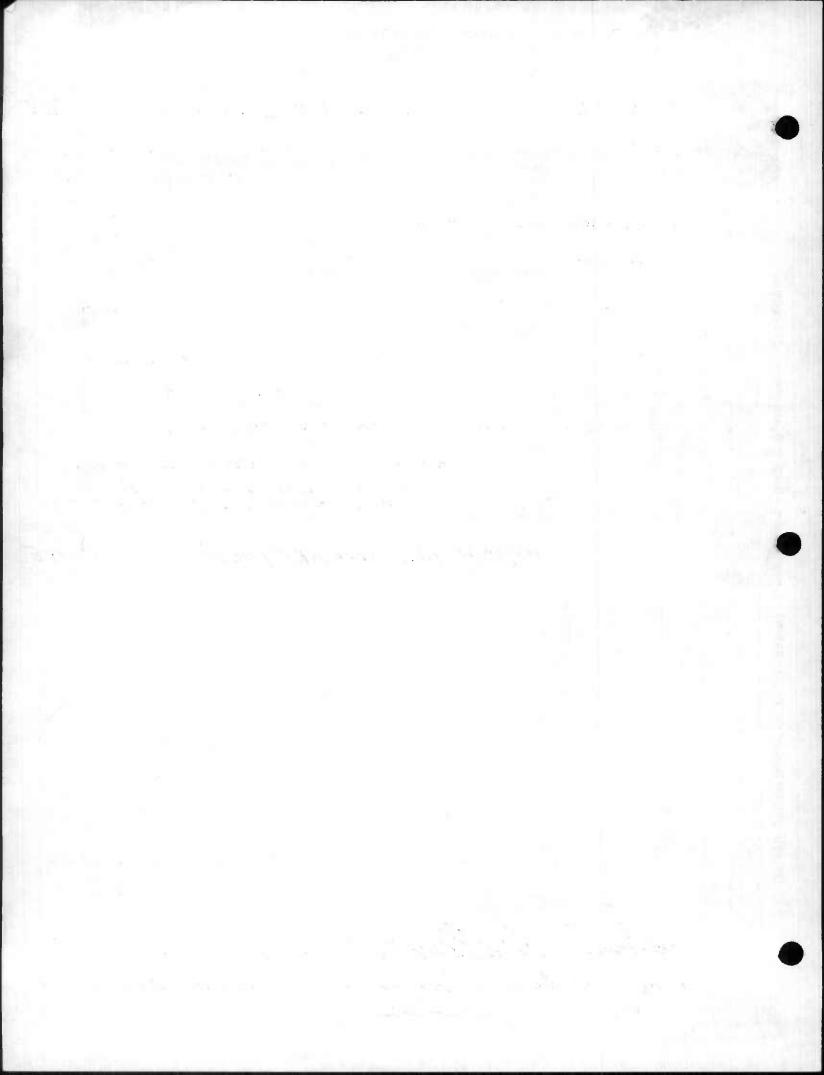
| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical To the Vithin 2 To the I 29b. Signeture end title of certific 29d. Date signed (Month, Dey, Yeer) 29c. License number 17-30469 February 22 2 30, Name and address of person who completed cause of death (Item 23e) (Type, Print) N. 13. VEU AWA, No. 7055 (TRV RULE) EllizoTT PRNe # 100; Mss D. 21042 31. Date filed (Month, Dey, Year) FEB 24 1998 Registrar's Signature Registrar

DHMH 16 Rev 6/95



					ent of Health and ate of Death		Reg. No.	06816
Physic /Medi	cal	Decedent's Name (First, Middle, Lase) DWARD 4a. Facility Name (If not institution, give	FRANK	KE	LLOGG	2. Date of De Month	Day	Year 3. Time of Death 2.40 P
Funeral Director	ner	Suburban Hospita 5. Social Security Number 6. Se 578-36-6686	1	last birthday) If Ur Yrs. Mont	Bethesd	a. 8. Date of Bir (Month, De	Mon	teomery 9. Birthplace (State or Foreign Country) Pennsylvania
yland		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Location				10d. Inside City Limits
the Mar	Director	Maryland Prince G	eorges Mt	. Rainier				1 ☐ Yes 2√∑ No
h with	N Dic	4007 35th Street		101.	Zip Code 20822		10g. Citizen of V	
72 hours after death with the Maryland netural; or items 23a or 28s-1 show deal Examiner must be netited at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, s	cedent of Hispanic Origin? (specify Cuban, Mexican, Puess 2 No Specify:	Specify Yes or No orto Rican, etc.)	- 14. Rac	e - American Indian, ck, White, etc. /:
	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life, DO NO	Isual Occupation work done during most of w Tuse retired)	orking	16b, Kind of B	White usiness/industry
	Ве Сош	12 17. Father's Name (First, Middle, Last)	College (1-401 3+)	Musician		ame (First, Middle,		ainment
Maryland d 2 should be file h and Mental Hy 7 Is marked oth traumatic event	To	Edward Kellog			Isabe		lttle	
and 2 sh and 2 sh aalth and n 27 is m		19a. Informent's Name/Reletionship (T	(cousin)		ess (Street end Number or I			
Delitimore, in permit. Pages 1 and Department of Health important: if Item 27 any Injury or other tr ance.		20e. Method of Disposition 1 Magurial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	Pleca of Disposition (cemetery, cremetory	or other place)	Date	20c. Location -	City or Town, State
Description permit. Pag Department Important: It eny Injury o		21. Signature of Funeral Service Licens	110	22. Name	Cemetery and Addrass of Facility			gton, D.C.
0 88 5 8		23a. Part I. Enter the disease, or comp	road	500 U	is J. Colling	d. W. Si	lver Sp	Inc. ring,MD 20901
Cata be executed by Sician and by Sician and by Sician and Sirie burial-transit	Examiner	Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	or as a consequenca	of):	10 N		ACUTE
5 D 6	edicai	resulting In death) Last	Due to (c	or as a c <i>ons</i> equenca o	of):			
death death of for	Physician/M	Part II. Other significant conditions co	ntributing to death but not res	uiting in the underlyin	g cause given in Part I.	23b. Did	tobacco use co	ntribute to the cause of death?
that the ed by detac	by Phy						Yes 2□ No	3 Probably & Unknown
aw requir	Completed						an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
vical nec						10	Yes 2/10	1 ☐ Yes 2 ☐ No
Physician: this certific ral director.	o Be	25. Was case referred to medical exeminer? 12 Yes 2 No	lospitel: 1 Inpatient 2	ÉR/Outpatient 3□	Othor:	eath (Check only of Home 5 ☐ Resid		or (Casada)
- 0 0 0	-	27. Menner of Deeth DENatural 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		how Injury occur	
	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Placa of Injury - At h building, etc. (Specif		tory, offica	28f. Location (: City or To		er or Rural Route Number,
To the Hospital or within 24 hours efte To the Funeral Dir. completaly lilled in	edical	29e. Certifier (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deeth occurr tion and/or Investigat	ed at the time, dete and place ion, in my opinion, death occ	e, and due to the curred at the time,	ceuse(s) end me date and place,	enner es stated. and due to the cause(s)
	Σ	29b. Signature and tale of sertifier	Selle	and a	29c. License number DOFO		-	d (Month, Dey, Year)
V		30. Neme end address of person who co	empleted cause of death (Item	23a) (Type Print)	D.	D		13 98 MD 20817
Sta	ite	31. Date filed (Month, Dey, Year)	AYLE 1021 32. Begistrar's Signe	S FERNO	000% ND	PETHO	SDAI	11020817

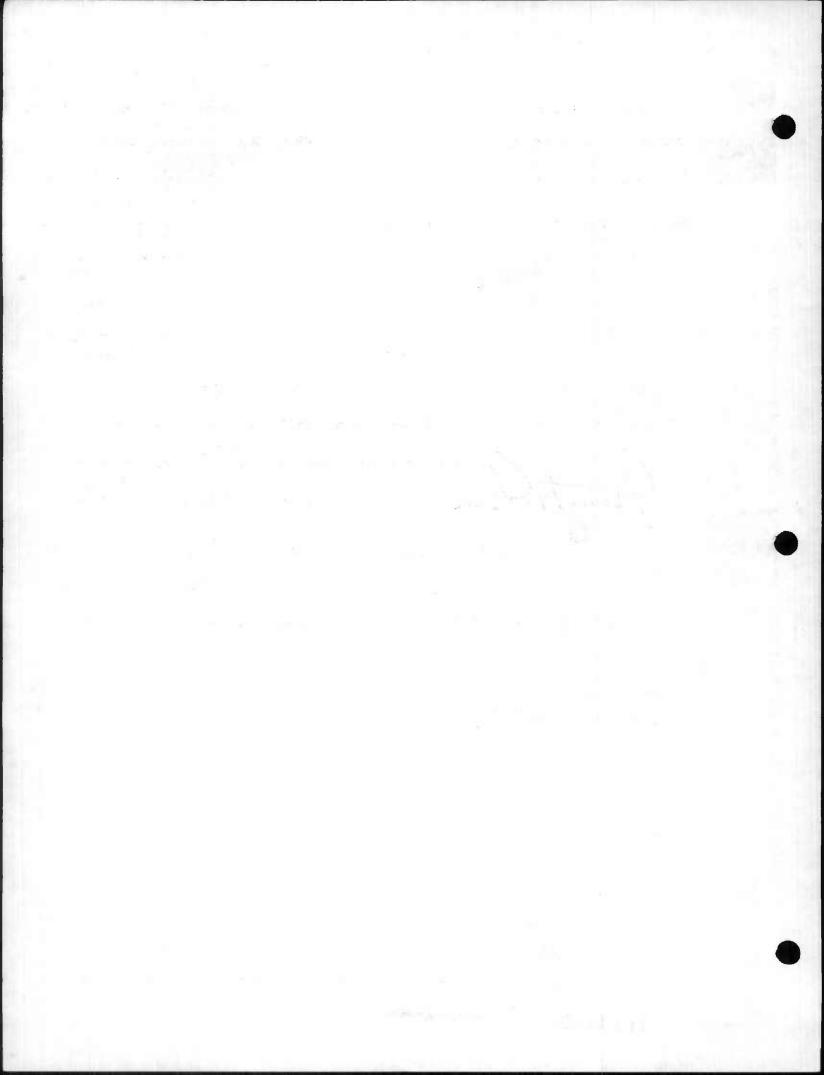
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Physici					Certii	ficate of	Deaiii		Reg. No.	0	0011
rilysic	an	1. Decedent's Name (First, Middle, Li	ast)					2. Date of Dea	ath Day	Year	3. Time of Death
/Medi		LeRoy Rob	ert K	estel				Februar			4:27 a.m
Examir		4a. Facility Name (If not institution, git	e street and number	r)			4b. City, Town, o	r Location of Death	4c. County	of Death	
		Manor Care of Ch	evy Chase				Chevy	Chase	Mont	gomer	y
Funerai Director			1DM 2DE	ige (In yrs. lesi 39		Under 1 Year lonths Deys	If Under 24 Hr Hours Min		r, Year)		lace (Stete or Foreig try) sylvania
how		10a. State 10b. County		10c. City, T	Town or Locati	on				1	0d. Inside City Limits
23a or 28a-f show	Director	Maryland Montgom	ery	Kens	ington						1□ Yes 2□ No
0 0	Dir	10e. Street and Number			1	10f. Zip Code			10g. Citizen of	What Coun	itry?
23		10404 Hebard Stre	et			20895			United	1 Star	tes
z nous ellar deall with the maryland hatural, or items 23a or 28a-f show iteal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	?] No		Decedent of Hes, specify Cubo	lispenic Origin? (en, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Rad Bia Specif	ca - Americ ck, White, o y:	
"natural",	P	15. Decedent's E	ducation	1	16a. Decedent	's Usuai Occup	ation	T	16b. Kind of B		
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Haaith em 27 ither tr		Thomas Kestel,	Son					Kensingto		2089	
or o		1 X Burial 2 □ Cremation 3 □	Removel from State	cemi	etery, cremato	on (Neme of ory or other place	⊝ (e)	Feb 20,	20c. Location	- City or To	wn, State
tant		4 Dogation 5 Other (Speci	/ /	Gate	7	aven Cer		1998	Erie, P	ennsy	lvania
Department of Important: If II any injury or once.		21. Signature of Funeral Service Lice	nsee /		22. Na	ame and Addre	ss of Facility	DeVo	1 Funer	cal He	ome
102 0 0		1 Janey	n. Te	w				r., Gaith		g, MD	20877
hysician		23a. Part / Enter the disease of com- shops, or heart failure. List only	plications that cause one cause on each	ed the death. I	Do not enter th	ne mode of dyir	ng, such es cardi	ac or respiratory ar	rest,	t	Approximate Interval Between Onset and Death
/Medical		Immediate Cause (Final disease or condition	. Acut.	e Cer	ehrova	scular	Accid	ent be	ft.	1	10 days
xaminer		resulting in death)	a	Due to (or as	s a consequen		1	ń	, ,		
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ha attending physici hed for usa as the bu	Medical	thet initiated events			e consequen	Candio L	en in Pert i.	DISAM_	obacco uae co	entribute to	feug
gned by the attending physici	Physician/Medical	resulting in death) Last	contributing to death	but not resultin	e consequen	Candio L	en In Pert i.		obacco uae co		o the cause of death
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within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attendiscompletaly filled in by the funeral director, paga 2 should be deteched for use	Medical Certification: To Be Completed by Physician/Medical	Part II. Other significant conditions of the con	Hospitei: 1 Inpat 28a. Date of inj (Month, D) 28e. Place of irp building, e	ient 2 ER ury ay Year) 28 signify - At home fic. (Specify) of examination teled.	//Outpatient (b) Time of Injury (b), ferm, street, and/or investigation (c)	ca of): rlying cause given gi	26. Place of Does of	24e. Wes a performance of the pe	en eutopsy med? es 22No ne) enca 6 Ott ow injury occur street and Numb n, Stete) euse(s) end m. tate and place, 29d, Date signe	3 Prob 24b. We avice of the avi	pably 4 Unknown are autopsy lindings allable prior to mpletion of cause deeth? Yes 2 No I Route Number, ated. the cause(s) Dey, Year)
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DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dey Feb 9,1998 **Physician** 01:07pm Vinod K. Khurana /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 9. Birthplace (Stete or Foreign 7. Age (In yrs. last birthdey) **Funeral** Deys 18 M 2□ F Months India Yrs. 359-38-2582 Sept. 13, 1943 Director 54 Usual Residence of Deceden the Meryland 10c. City, Town or Location th and Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a-f show tranmatic event, the Medical Examinet must be notified at 10e Stete 10b County 10d. Inside City Limits Prince Georges Riverdale 1 ☐ Yes 2 ☐ No Maryland Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? United States 6404 63rd PL. 20737 death Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11. Meritel Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or flar may injury or other traumatic avent, the Medical Examine DAGE. 1 ☐ Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Tyes 2 No Specify þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Bar Manager 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Mohini Sakhuja Vishnu Dutt Khurana 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Prem K. Khurana - Wife 6404 63rd. PL. Riverdale, MD. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State Northern Virginia Crematory 2/12 Arlington, VA. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funerel Service Licentee Arlington Funeral Home. 3901 N. Fairfax Dr. Arlington, VA. se, or complications that caused the Do not enter the mode of dylng, such es cardiec or respiretory errest, Approximete Intervel Between Onset and Deeth 23a. Pert1. Enter th **Physician** /Medical Immediate Ceuse (Finel ACUZE MYOCARDIAL INFARCTION MINUTES diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner 4BARS PAILUNG CHRONIC RENA physician and s the burial-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) the death certificate be exec YBARS Box 68760 DI 836781 MRUITUS Physician/Medical Due to (or es e consequence of) 80 CHOUSN41715 DAYS 150 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 20 No 3 Probably 4 Unknown MISTORY RANK TRONSPUGOUT þ 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed hes 1 ☐ Yes 2 XNo 1 TYes 2 TNo certificate if or Attending Physicien: efter death. Director: After this certifica funeral director, 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2□ER/Outpetient 3□ DOA P 27. Manner of Death 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Netural Injury 5 Pending investigetion 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 T Homicide n 24 hour. 29e. Certifier 🖎 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29b. Signeture end title of card 29c. License number 29d. Date signed (Month, Dey, Year) MD 02427 Feb 11,1998 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
Ajay Bakshi Md 9406 Old Georgetown Rd Bethesda, Md 20814

State Registrar 31. Date filed (Month, Day, Year) FEB 18199 32 degistrer's Signeture

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	Physic		JALLE KO	RTCKT							Month FEB.	11, Dey	98 Year	12:41 F	PMC
	/Medi			(If not institution,	give street end n	rumber)		· · · · · · · · · · · · · · · · · · ·		4b. City, Town, or I			unty of Deeth		-
	Examir	ier		BRASSIE	ALL PROPERTY.					GAITHE	RSBURG	IM.	ONTGOM	(EDV	
1	Funeral		5. Sociel Security	-	. Sex	7. Age (In)	yrs. last birti		nder 1 Yea		8. Date of B			plece (Stete or Fore	aigi
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	yland		10a. Stete	10b. County		10c.	. City, Town	or Location						10d. Inside City Lim	
	the Marylar 28a-f show	tor	MD	MONTG	OMERY		GAI	THERSE	BURG				1 ☐ Yes 2		No
	or 284	Directo	10e. Street and N	lumber				10f.	Zip Code	9		10g. Citizar	10g. Citizan of What Country?		
	th will		19605 BR	RASSIE PL	ACE				20	877		US	A		
	Herns ?	Funeral	11. Marital Stetus	S	12. Wes De	cedent Ever I	In U,S.	13. Was De	ecedent o	f Hispanic Origin? (S	(Specify Yes or No- orto Rican, etc.)		Race - Amer Bleck, White		
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215-0020	in 72 hours "natural", Buical Ex			15. Decedent's ecify only highest	Education		16a.	Decedant's U	Jsuel Occ	cupation ne during most of wor	kina	16b. Kind	of Business/l		
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Baltimore,	00		20e. Mathod of D	isposition 2 Cremetion 3	20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stet										
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m			23a. Part1. Enla	r yng disease, or co						tylng, such es cardiac			E, MD	Approximate	-
	Physician		shock, or he	eart failure. List or	ly one cause on	eech line.							1	Onset end Deeth	
	/Medical		Immediate Ceus		ALL	20001	10-11	- 11	-di	ovisculu	- di	inse			
	Examiner		diseasa or condi- resulting in daeth	tion n)	a					ovoscucu	1 0010	160-16			-
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. B	the etten	SICI	Pert II. Other sign	nificant conditions	contributing to	death but not	resulting in	the underlyi	ng cause	given in Pert I.	23b. Dio	tobacco us	e contribute	to the ceuse of dea	eth
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ecords,	S 5 8	d by									24e We	s en eutopsy	24b. V	Vera eutopsy findin	os
O	neen Noul	Completed									per	iormed?	6	eveileble prior to completion of cause	
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of	2 00	2	1]X) Yes 2[-	-		tpatient 3	DOA		lome 50 Ras			ify)	
	After After funar	on on	27. Manner of De 1 ☑Natural	5 Pending		e of tnjury onth, Day Yea	28b. T	njury M	28c. In	Vork? □ Yas 2 □ No	28d. Dascribe	now injuly o	ccuned		
Sic	Attending ir death. actor: After by the funa	Cat	2 Accident 3 Suicide	investiga 6 Could no	he	as of Indiana.	At home for				29f Location	(Street and A	lumber or Ru	ral Routa Number,	
Division	or Attendation of the deat	Certification:	4 Homicide	dotormin	288. PIBE	ca of Injury - A ding, etc. (Sp	ecify)	m, street, fa	cory, offic	26		own, Steta)	CARDO OF MU	riouta rumbur,	
	the Hospital or Attending Ph hin 24 hours after death. the Funeral Director: After th mpletaly filled in by the funaral		29a. Certifier	1 Carlhi-	Dhyeloles: To th	no hoet of mi	knowledge	death assure	rad at the	time, dete end place	and due to the	couse(s) on	d mannar sa	etated	
	the Hospita hin 24 hours the Funeral npletaly filled	edical	(Check only one)	2XXMsdical Ex	aminer: On the	basis of examination	nination and	/or invastiga	tion, in m	y opinion, deeth occu	rrad et the time	, dete end pl	aca, end dua	to the ceuse(s)	
	ithin of the omple	M	29b. Signeture er	nd title of sortifier	6	/			29c. Lice	ense number		29d. Date s	igned (Month	n, Dey, Year)	-

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Fork

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

FEB. 12, 1998

State Registrar

31. Date filed (Month, Day, Year) FEB 1719

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State Devi. of Health and Mental Horlene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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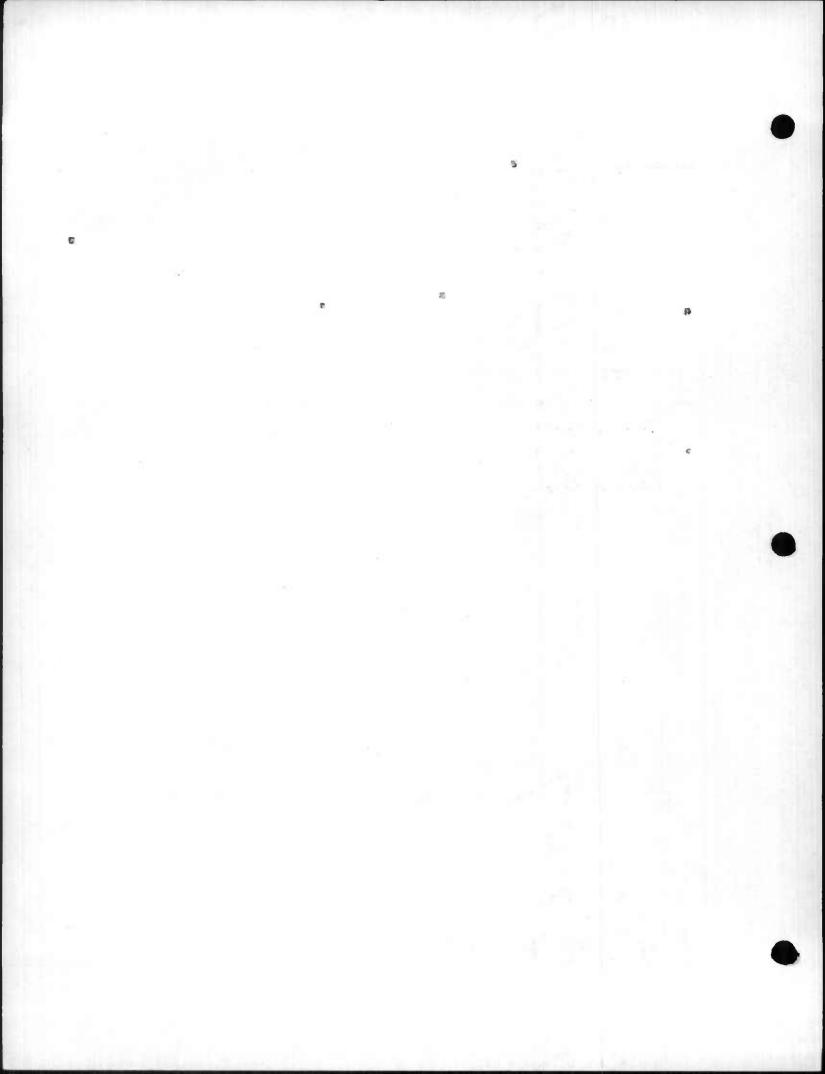
John F. Fenwick, M.D.

31. DATE FILED (Month, Day, Your)
FEB 24 1998

32 REGISTRAR'S, SIGNATURE
Julia Dhudian Road 11

Ite	em:4 per FH G-757 3/19/98 dh FOR STATE OF MARYLAND / DEPARTMENT OF HEALT CERTIFICATE OF DE		HYGIENE REG. NO.	30 00020
	1. DECEDENT'S NAME (First, Middle, Last) Ruth Lehr Kaiser	2. DATE (MONTH Febru	OF DEATH DAY	1998 2:15 AM M
	4. SOCIAL SECURITY NUMBER 725-07-3729 1 M 2 F 102 9a. FACILITY NAME (If not institution, give street and number) 5. SEX 1 M 2 F 102 9b. CITY, TOWN OR LOC	Januar	F BIRTH Day, Year) y 30, 1896	8. BIRTHPLACE (State or Foreign Country)
TOR	St. Mary's Nursing Center Leonardt			t. Mary's
DIRECTOR	Maryland St. Mary's Mechanicsvil	le		10d. INSIDE CITY LIMITS? 1 YES 2 INO
FUNERAL		0659	100	ited States
BY		TOF HISPANIC ORIGIN: uban, Mexican, Puerto R NO Specify:		- 14. RACE - American Indian, Black, White, atc. Specify: White
APLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4 or 5+) 12 15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of work life. Do NOT use retired.) HOMEMAKET	orking 15b.	KIND OF BUSINESS/	INDUSTRY
BE COMPL	Harry Lehr Amer, Sr. Et	other's name (First, M hel E. Ste	ele	
5	19a. INFORMANT'S NAME (Type/Print) Jacqueline Kaiser-MacBryde 19b. MAILING ADDRESS (Street and Num 38950 Holly Bank			
	20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			- City or Town, Blata and, Maryland
		ld Funeral	Home, P	
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Car Alaic arsky flux in Due to (or as a consequence of):	dying, auch as card		
NOITA	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING	luce		Emo.
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	recen	•	242.
PHYSICIAN: MEDICAL CE	PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause to the conditions contributing to deeth but not resulting in the underlying cause to the conditions contributing to deeth but not resulting in the underlying cause to the conditions contributing to deeth but not resulting in the underlying cause to the conditions contributing to deeth but not resulting in the underlying cause to the conditions contributing to deeth but not resulting in the underlying cause to the conditions contributing to deeth but not resulting in the underlying cause to the conditions cause to the condi	te given in Part I.	24a. WAS AN AUTOP PERFORMED? 1 YES 2 NO	AVAILABLE PRIOR TO
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inputient 2 ER/Outpatient 3 DOA 4 Nursing Home 5	F DEATH (Check only on		
ву Рну	27. MANNER OF DEATH 1. Natural 5 Pending Pe	T 28d. D€\$	CRIBE HOW INJURY	OCCURED
	3 Suicide 5 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		NTION (Street and Nun or Town, State)	nber or Rural Route Number,
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, data and plone) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death oc			
BE	29c. 1	LICENSE NUMBER	29d.	DATE SIGNED (Month, Day, Year) 2 - 2 2 - 9 &
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)	-		

22650 Cedar Lane Court, Leonardtown, MD 20650



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death February 23, 1998 **Physician** Charles Henry Knott 3:15 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Yeer If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
Months Days Hours Min. July 22, 1908 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1 ■ M 2 □ F 89 Yrs. 220-16-4565 Director Usual Residence of Decedent the Marylend 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ■ No Director Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be 19865 Three Notch Road 20653 United States Funerai 72 hours after death 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ■ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusinass/Industry filed within 7 Hygiena. College (1-4or 5+) Elementary/Secondary (0-12) Construction/Fishing Waterman/Carpenter 18. Mother's Name (First, Middle, Maidan Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill mant of Health end Mentel Hy ant: If Item 27 is marked oth jury or other traumatic event William Henry Knott Anna Mae Goddard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Wife 19865 Three Notch Road, Lexington Park, MD 20653 Lina E. Knott, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from Stata Trinity Episcopal 2/27/98 St. Mary's City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Brinsfield Funeral Home, P.A. Blankenshi 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that could be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on ago line. Approximeta Intarval Batween Onsat and Death **Physician** /Medical Immediate Causa (Final diseasa or condition rasulting in daath) 5-Due to (or as a consequence of): Examiner Examiner Dua to (or as a consequence of): physician end s the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760 atheroselstic lenkerraseular deser Physician/Medicai Due to (or as a consequence of): 00.00 ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 22 No 3 ☐ Probably 4 ☐ Unknown by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed prestatic hypertrophy / Cystitis 1 Yes 28 No 1 ☐ Yes 2 ☑ No Division of Vital Attending Physician: director. Be 25. Was case referred to medical examinar? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2€ No funeral 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: 28a. Data of Injury (Month, Day Year) 5 Panding investigation 1 Natural Euneral Director: After details in Euneral Director: After interest of the further furthe 1 Yes 2 No NIA NIAM NIA 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Spacify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò NIA 29a. Certifier ধ Certifying Physician: To the best of my knowledga, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signeture end litle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47825-(MD) 2-25-98 Caseix W. Tumore MD 6

Registrar

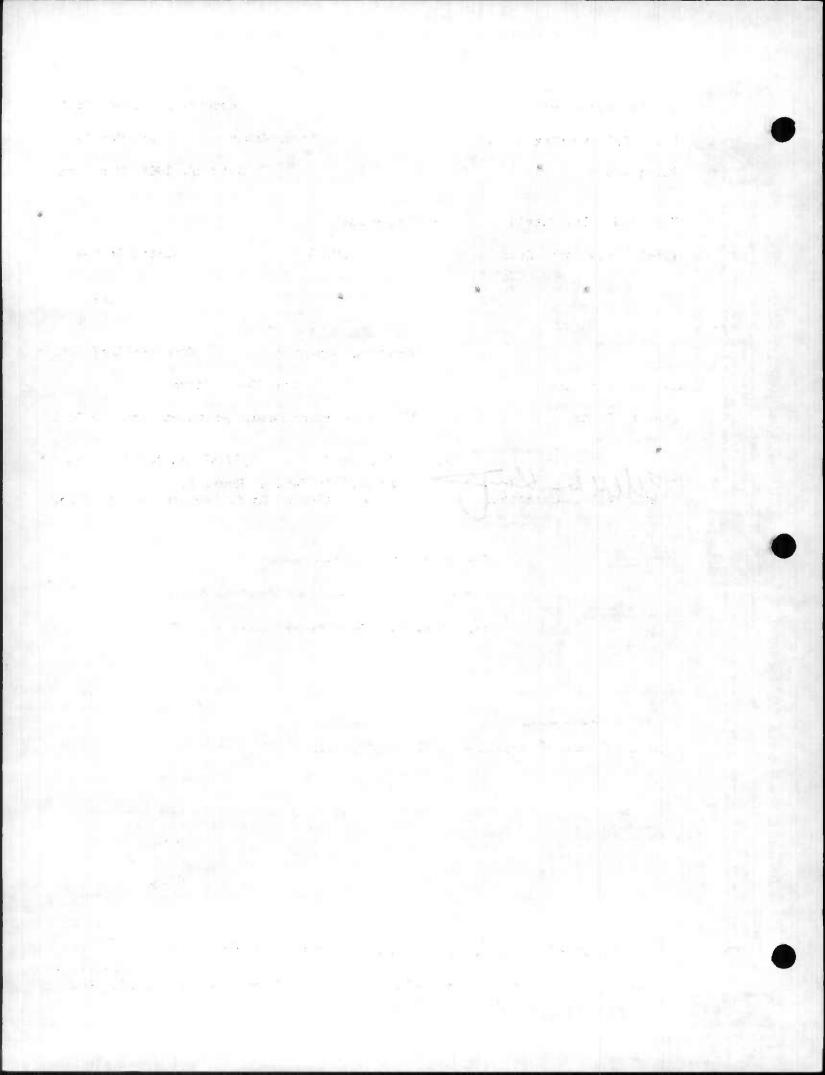
31. Date tiled (Month, Day, Year) FEB 27 1998

ROBERT

TIMMONS 32 Registrar's Signature Randall HOLLYWOOD

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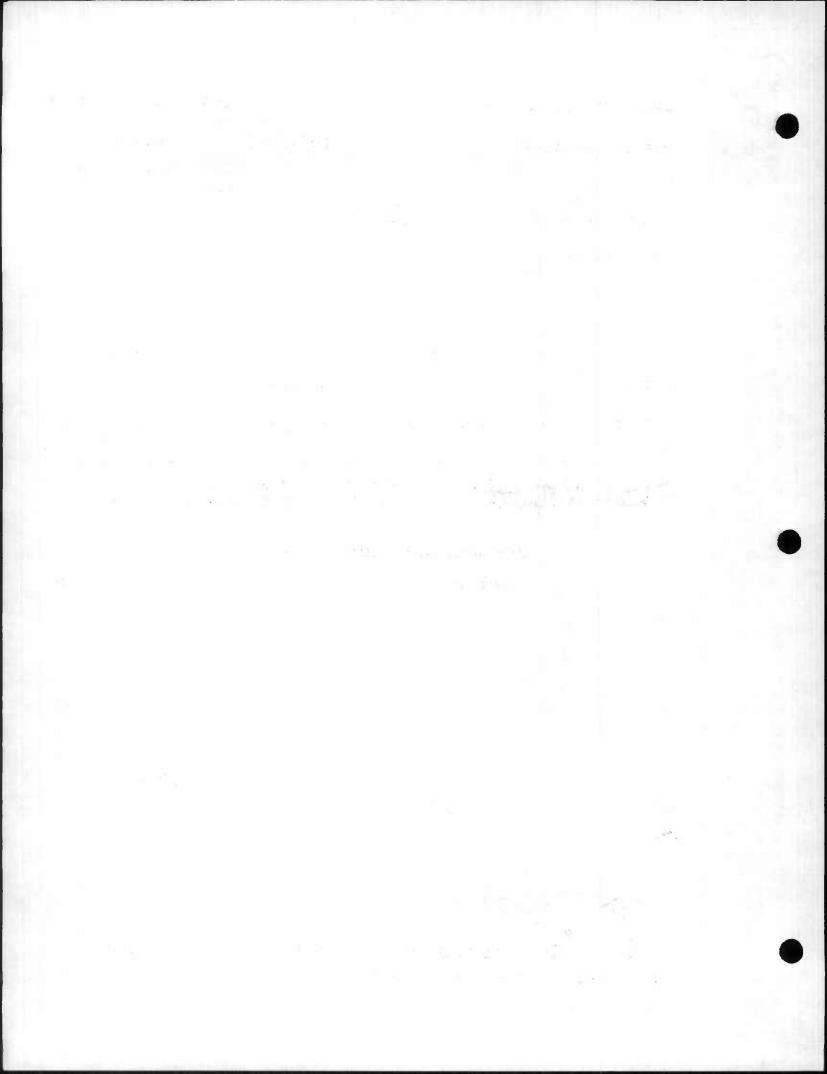
30. Name and address of person who complated causa of daath (Itam 23a) (Type, Print)



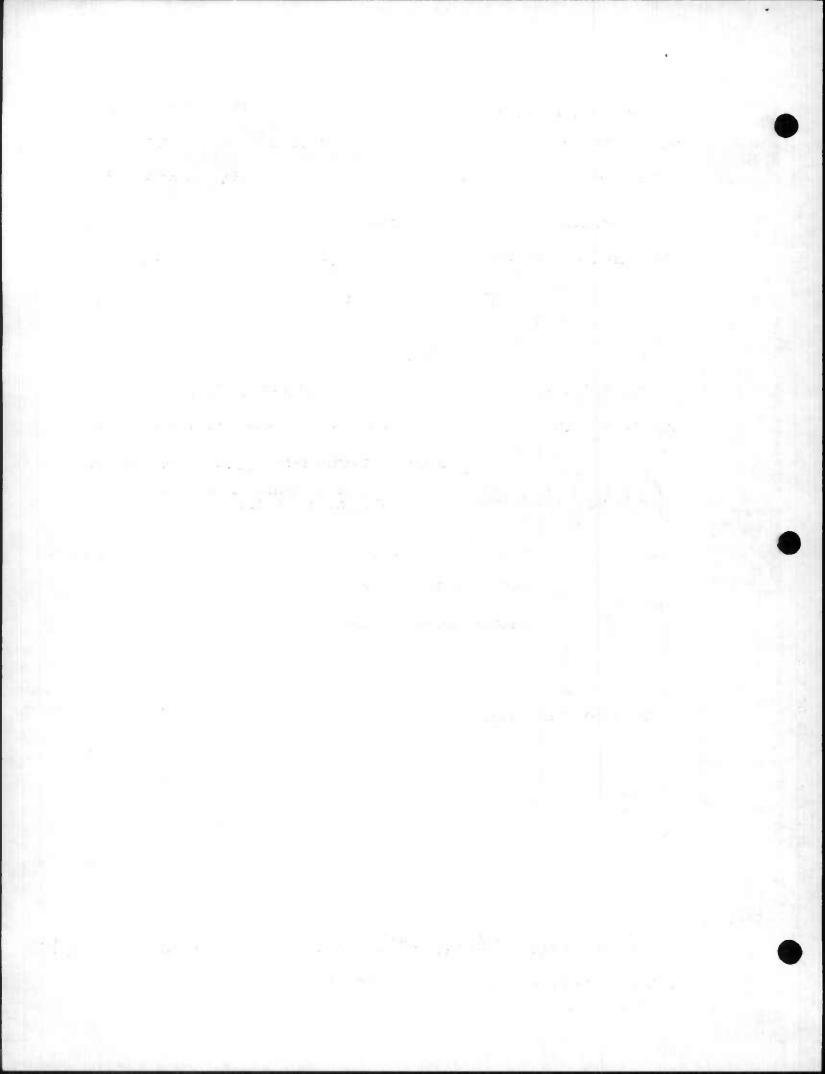
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** reb 18 1998 10:48PM Helen Catherine Kastner /Medicai 4a. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Allegany Cumberland Memorial Hospital
5. Social Security Number 6. Sex Hours Min. 8. Dete of Birth Month, Day, VAPRIL 24 If Under 1 Year 9. Birthplece (State or Foreign Country)
MARYLAND 7. Age (In yrs. lest birthday) **Funeral** Months Deys 1 M 2 TF 74 Vrs Director 215-14-6167 Usual Residence of Dacedent the Maryland Show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinal must be notified at MXYes 2 No Directo MARYLAND ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 1508 G OLDTOWNE MANOR 21502 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ②No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours efter of neath and Mental Hygiene.
Alt: If Item 27 Is marked other than "natural", or files
INY or other traumalic event, ITE Medical Examines 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 💢 No þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) Collega (1-4or 5+) 12 HOUSE KEEPER HOUSE KEEPER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be JAMES DOYLE HELEN JONES Lo 19a. tnforment's Name/Relationship (Typa, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) HUSBAND 1508 G OLDTOWNE MANOR CUMBERLAND MARYLAND 21502 20b. Place of Disposition (Nama of WILLIAM D. KASTNER Baltimore, 20b. Place of Disposition (Nama of cemetery, cremetory or other plece) 20e. Mathod of Disposition Flintstone XXBurial 2 Cremetion 3 Removal from State permit. Pege Department of Important: If any injury or injury or ROCKY GAP VETERANS CEMETERY FEB23 1998 RFD MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama end Address of Fecility
MERRITT-ADAMS FUNERAL HOME 21. Signature of Funerel Sarvice License 404 DECATUR STREET CUMBERLAND MARYLAND ox 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) /Medical Uk yrs Arteriosclerotic heart disease Examiner Dua to (or es e consequence of) Examiner Uk yrs Diabetes ician and burial-transit the death certificate be executed Sequentielly list conditions, if eny, leeding to immadiate ceuse. Enter Undarlying Ceusa (Disaasa or injury that initiated evants resulting in daeth) Lest Due to (or es e consaguance of): physician s the burial Box 68760 Physician/Medical Due to (or es e consequence of) 88 esm 0 signed by the a Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yes 2 No 3 Probably Unknown Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of daeth? 24a. Wes en eutopsy performed? Completed peen page 2 certificate hes 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes cesa raferred to medical axaniner? Be 26. Place of Deeth (Check only one) axaminer? 1/☐ Yes 2 ☐ No Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatiant 2SER/Outpetient 3□ DOA funeral 27 Marinar of Deeth 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Dascribe how injury occurred Hospital or Attanding P
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 Funeral Director: After ti Certification: After 5 Panding Investigation 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) á 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in critifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the causa(s) end menner es steted.

The dicel Examiner: On the pasts of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) and manner stated. edicai 29a. Certifler 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) Feb 18 1998 D 09167 Dpty Md Ex ass of person who completed cause of daeth (Itam 23a) (Type, Print) 124 w 3rd st Cumb Md 21502 Paul Snow, M.D. 1260 324 Registrer's Signeture State July 2 Way way Registrar



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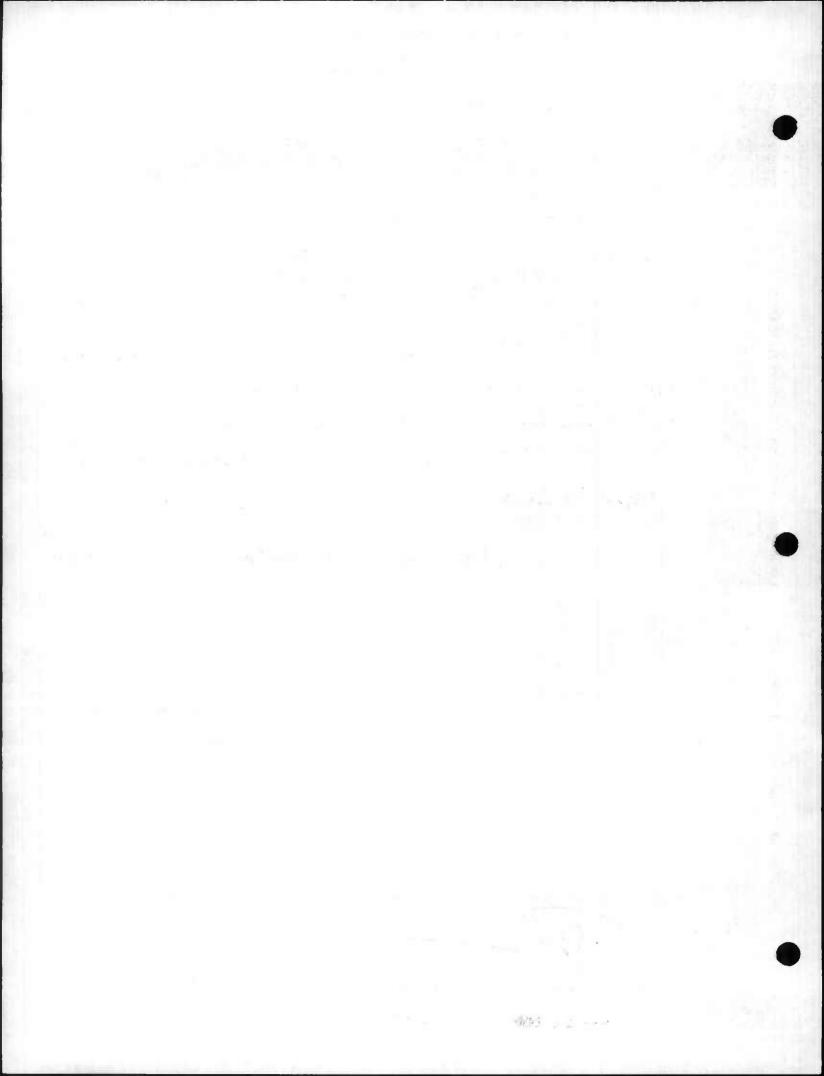


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_	Decedent's Name (First, Middla, Last)	nate of Maryla		Certificate of			Reg. No.	068	me of Death	
Physician /Medical Examiner		JOSEI	PH KENN	ЕТН	KELLY		Month Februar	Day	Year	55 A.M.	
		A Coult of the state of the sta				4b. City, Town, or				33 A.M.	
		Home- 26278 Peach	Street			Crisfie	eld	Somer	set		
Funera Director		5. Social Security Number 213-26-2724 Control of the second of the seco						8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) February 22, 1930 Maryland			
d 21215-0020 filed within 72 hours after death with the Maryland Hygiena. frier than "natural", or thems 23a or 28a-f ahow wit, the Medical Evariane mant be notified a	Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
		Maryland Somerset Crisfield							1 ☐ Yas 2 No		
		106. Street and Number 26278 Peach Street 21817						10g. Citizen of What Country? U.S.A.			
		11. Marital Status 1 □ Navar Marriad 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Larmed Forcas? 2/2 If Yes, Give Yaar or Dates:			J.S. 13. Was Decedent of Hispanic Origin? (Specify of Marcon, Pular of Rican) 149 1 Yes 2 No Specify:			or No- c.) 14. Race - Amarican Indian, Black, White, etc. Specity: White			
		15. Decedent's Education (Specify only highest grade completed)			Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)		rking	16b. Kind of Business/Industry			
within ena.	ig I	College (1-40r 5+)						Bethlehem Steel Corp			
aryland 212 should be filed withind Mantel Hygiens. i merked other than		OGGZ HOLKE				18. Mother's Name (First, Middle, Maiden Surname)					
lan lan lan lan lan lan lan lan lan lan	To Be	Samuel Edward Kelly				Martha Hewett			arson Sumano,		
Maryland d 2 should be file th end Mantel Hy 7 is merked othe traumatic event	-						f Number or Rural Route Number, City or Town, State, Zip Code)				
C - 01 .		Jeanette M. Kelly (Wife)	262	278 Peach S	Street- C	risfiel	d, MD 2	1817		
Baltimore, M semit. Pages 1 and 2 Department of Health e mportant: if item 27 is ny lojury or other tra					hisposition (Name of crematory or other plates) Spe Memorial		Date 2/17/98	20c. Location - City or Town, State Crisfield, MD			
Baltimo pemit. Page Department of important: If any Injury or one.		21. Signature of Funeral Service Licensea 22. Nama and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St Crisfield, MD 21817									
Physician		23a. Part 1. Enter the disaasa, or complications that caused by doubt. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, Approximate									
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BOX 68/60, eath certificate be executed ettending physician end I for use as the bunal-transit	n/Medical Examiner	b									
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LIVISION OT VITA To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	2	1 ☐ Yes 2 No Hosp 27. Manner of Death	1 □ Inpatient 2	1 Inpatient 2 ER/Outpetient 3 DOA Nursing Home 5 X Residence 6 Other (Specify)							
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	ficat	2 Accident investigation 3 Suicide 6 Could not be					28f Location /	28f. Location (Street and Number or Rural Route Number,			
	Certification:	4 Homicide determined					City or To	City or Town, State)			
	edicai C	29a. Certifier (Check only one) 12 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	Me	29b. Signature and titla of certifier 29c. Licansa number					T	29d. Data signed (Month, Day, Year)			
		1 /2 /m N.D. 030690						Feb. 16, 1998			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
		James F. Martin M.D 145 F. Carroll St. Salisbury MD 21901									
St		31. Date filed (Month, Day, Year) EB 1 8 19	32. Registrar's Sign	nature	P. J.II		4				
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altimore, Maryland 21215-0020	permit. Peges 1 end 2 should be filed Department of Heelih end Mental Hyg Important: If Item 27 is marked other eny Injury or other traumatic event, once.			position		ate	_	position (Neme of emetory or other ple cematory		2/10/98	20c. Location		
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ion of	Attending Physic death. actor: After this by the funeral		27. Menner of Deetl 1 Notering Accident	h 5 Pending investigation		Injury Dey Year)	28b. Time Injury	Wo	ry et rk? Yes 2 □ No	28d. Describe	how injury occur	red	
Division	or Attand after death Director:	Certification:	3 Suicide 4 Homicide	6 Could not be determined	∠oe. Fleca of	injury - At hor , etc. (Specify	me, term, s	street, tactory, offica		28f. Location (City or To		ber or Rura	l Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funerel Director: After completaly filled in by the fune	edical C	29a. Certifier (Check only one)	1⊠ Certifying Phy 2☐ Medical Exam	veician: To the be iner: On the basi	s ot examineti	rledge, dee on end/or l	oth occurred et the til investigation, in my c	me, date end pleca opinion, deeth occu	, end due to the irred et the time,	cause(s) end mo dete and plece,	enner es st and due to	eted. the cause(s)
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		1) (CHI				D23	979		2/7	/98	
		,	30. Neme end add	ess of person who d	completed cause	ot deeth (Item	23e) (Type				-11	, , ,	
		4	Dr. Robe	rt Gorals	ski, MD	311 N	I. For	urth St.,	Oakland,	MD 21	550		
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				- LP 2 0	1220 3	Mighel Sept. (1)	-						



Director

Funeral

þ

Completed

Be

10d. Inside City Limits

Approximate Intervel Between Onset end Deeth

3 Probably 4 ☐ Unknown

1998

3 weeks

1 XYes 2 No

10:15 pm

Funeral

Director the Maryland show

r than "naturel", or items 23s or 28s-f shov the Medical Examiner must be notified at

21215-0020

altimore, Maryland

filed within 72 hours efter I Hygiene. i. Pages 1 and 2 should be filed w tment of Heelth and Mental Hygie fant: If itsm 27 is marked other to ulury or other traumatic svent, In Department of Heelth ar Important: If itsm 27 is any injury or other trau

Physician /Medicai Examiner

the death certificate be exec the signed by 99 director, pege 2 should certificete has Vital offer deeth.

Director: After this certifice of Division filled in by the

220-28-9459

MARIAN LANCASTER

Physician/Medical þ Completed Be P 27. Manner of Death Certification: 29e. Certifier Medical

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth Month MARIAN MAE LANCASTER February 19, 1998 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Memorial Hospital Cumberland If Under 24 Hrs. 8. De Allegany If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Dey, Yeer) Months Deys Hours Min. 1□M 20F Yrs. 1933 NOV 6 MARYLAND Usual Residence of Decedent 10e State 10b County 10c. City, Town or Location MARYLAND ALLEGANY FROSTBURG 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 171 CENTRE STREET 21532 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 11 Marital Stetus 13. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) HOWARD DAVIS NIDA PORTER 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BRENDA McKENZIE / DAUGHTER 2270 OLD FROSTBURG ROAD, FROSTBURG, MD 21532 20b. Placa of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, Stete Date 4 ☐ Donetion 5 ☐ Other (Specify) FROSTBURG MEMORIAL PARK 2/22/98 FROSTBURG, MD 21532 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility SOWERS FUNERAL HOME, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in death) e. Pneumonia -- Community Acquired

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest

exeminer?

1 Neturel

2 Accident

3 Suicide

4 Homicide

(Check only one) 29b. Signature and t

1 Yes 2 No

Due to (or es e consequence of): Due to (or es e consequence of)

Due to (or es e consequenca of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Respiratory Failure, Morbid Obesity, Asthma, COPD,

IDDM

25. Wes case referred to medical 26. Piece of Deeth (Check only one)

1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

24a. Wes en eutopsy performed? Were eutopsy findings eveileble prior to

1 Yes 2 No

23b. Did tobacco use contribute to the cause of deeth?

completion of cause of deeth? 2 No 1 Yes 1 Yes 2 No

Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated.

D 18769

29c. License number

29d. Date signed (Month, Dey, Year)

February 21

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Raver, Memorial Hospital, Cumberland, MD

Dr. James 31. Dete filed (Month, Day,

6 Could not be determined

of certifier

31. Registar's Signature

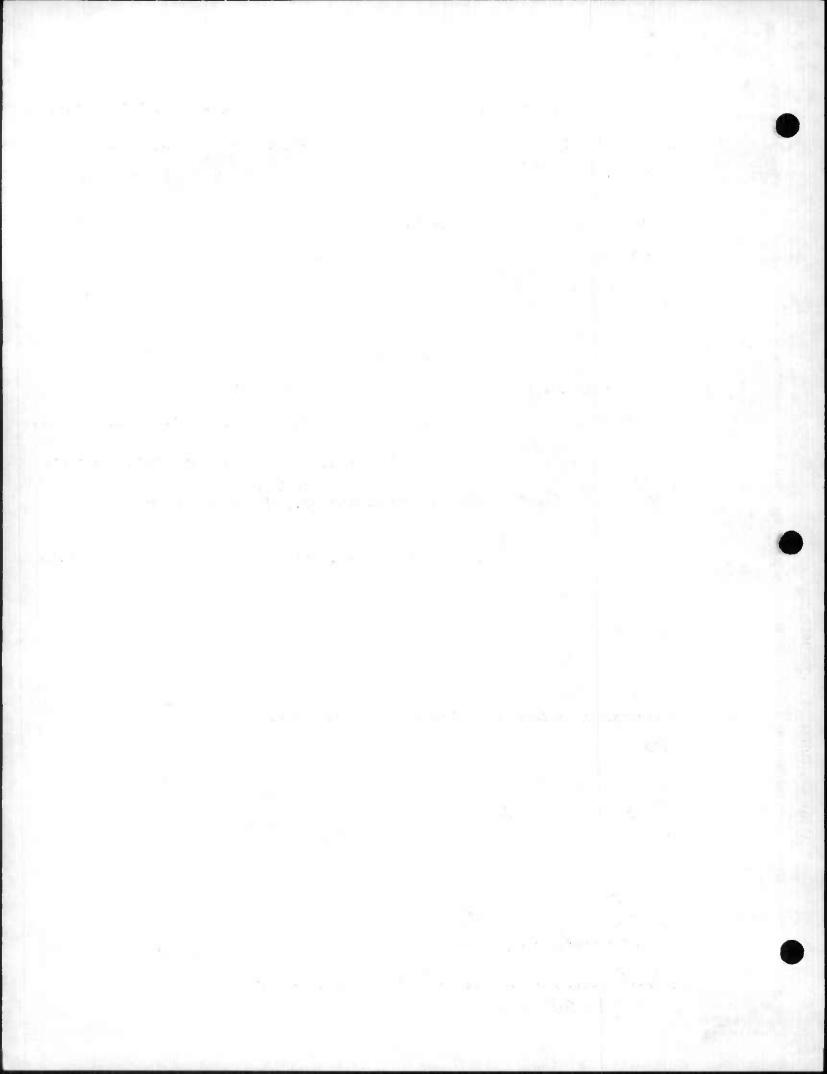
Hospital 24 hours

To the Hosp within 24 hos To the Fune completely fi

5

THIS

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

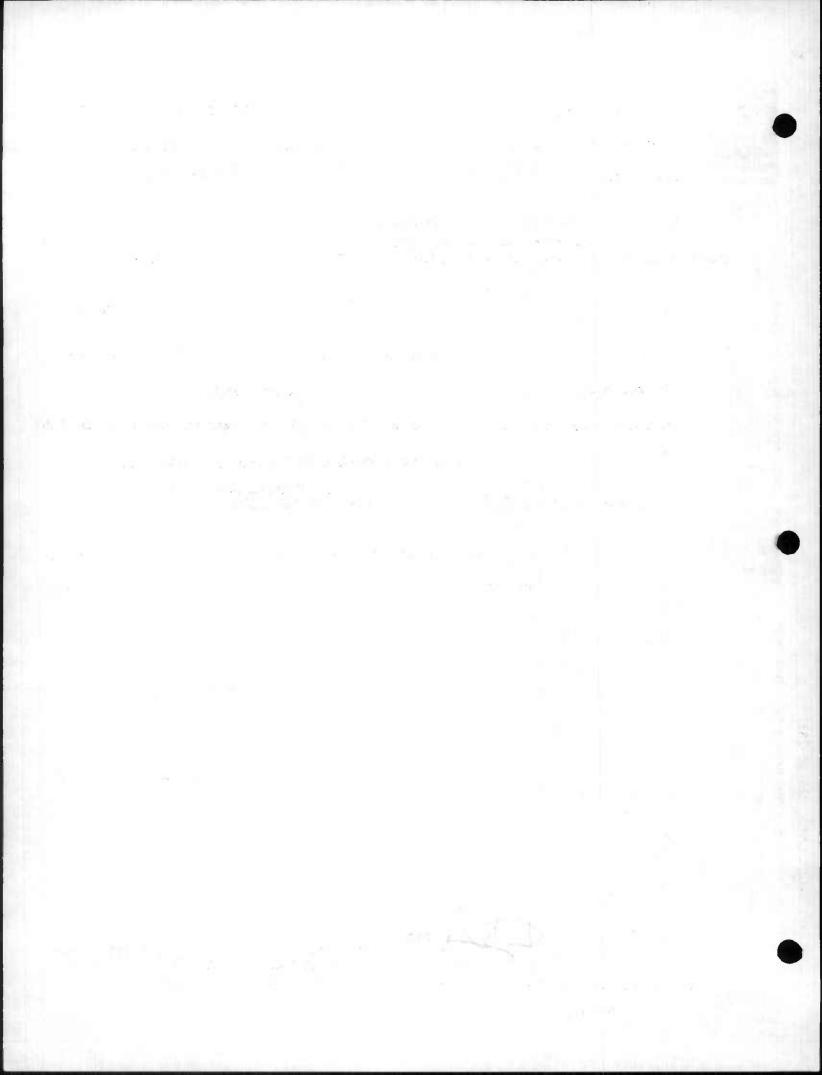
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Social Scientific Number 2.5 Marked 7.5		Examir	ner				mber)				4b. City, Town, or	Location of Dea			
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29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signeture and title of periller 29c. License number 29d. Date signed (Month, Dey, Yeer) D 43497 FEBRUARY, 23, 1998 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) DANIEL LEIBMAN M.D., MEMORIAL HOSPITAL SUITE 400, CUMBERLAND, MD 21502	5	s cert			No	Hospital:	Inpatient 2	FR/Outpaties	nt 3 D	OA O	ther			her /Snecif	v)
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DANIEL LEIBMAN M.D., MEMORIAL HOSPITAL SUITE 400, CUMBERLAND, MD 21502		7		20 Nome at 1 1	11/1	ammilia di		- 00cl /P		U 43	49/		TEBRUA	24,2	3, 1998
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			to			D., ME	PIOKIAL legitrar's Signa	HUSPIT	AL SI	JITE	400, CO	IREKLANI	, MD 2	1502	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

hysician		. Decedent's Name (First, Middle, L.	aqt)	100	Certifica	ate of I	Death	2 Date of D	Reg. No.	20	U 5 8 2 8
.,								2. Date of D Month	Day		3. Time of Dea
/Medical		Nola May Lane a. Facility Nama (If not institution, gi		a .			D. Cit. Town	FEBRUA		1998	
xaminer	-)		4	b. City, Town, or		(f) 4c.	County of	Death
	4	Memorial Hospi			total of the	dor 1 Voor	Cumberla If Under 24 Hrs		AJ	lega	ny
nerai	5		Sex 7.A 1□M 2√2 F	ge (In yrs. last i	Yrs. Month	der 1 Yaar ns Days	Hours Min.	(Month, D	ey, Year)	9	Birthplaca (Stata or Fo Country)
ector	1	211-20-7377 Isuel Residence of Decedent	31	85	113.	<u> </u>		Feb 2	20, 19	912	MD
E		Oa. State 10b. County		10c, City, To	wn or Location						10d. inside City Li
Olrector	;	100 277									1 ☐ Yes 2
be notified	1	MD Allegan Oe. Street and Number DO B			wlings	7. 0. 1.				4.44	
		PU B	ox 329 B	loomir	gfield	Zib Code			10g. Citiz	en of Wh	eat Country?
Mole	1	le Home Park R				21557				USA	
Funer	1	1. Marital Status	12. Was Decedent Armad Forces	?	13. Was De	cedent of Hi pecify Cuba	ispanic Origin? (S n, Mexican, Puer	Spacify Yes or N to Rican, etc.)	0- 1		- Amarican Indian, White, etc.
2 20 -		1 Nevar Married 2 Married	1 Yes 2 If Yes, Give		1 ☐ Yas	3√□ No	Specify:			Specify:	
natural Ex-		3 Widowed 4 □ Divorced	Yaar or Dates:								white
rt, the Medical		15. Decedent's E (Specify only highest gr		16	a. Decedent's U: (Give kind of	work done o	during most of wo	rking	16b. Kin	d of Busi	ness/Industry
omp		Elementery/Secondary (0-12)	College (1-4or		life. DO NOT		·				D11 1
Se Co	-	12 7. Fathar's Name (First, Middla, Las	4)	Ma	chine 0	perate		(F) . A(I) II			n Blinds
Be Se	i I		0				18. Mother's Na	ma (First, Middle	a, Maiden S	Sumame)	
To To		Andrew Byrd					Belinda		-		
Taum Taum	1	9a. Informant's Name/Relationship	(Type, Print)	15	b. Mailing Addre	ess (Street a	and Number or R	ural Route Numi	ber, City or	Town, St	tete, Zip Code)
y other traumatic event, II	_	Judith Holbrook	-daughter	I	O Box 3	29 Lo	t 4A Blo	omingfi	eld F	awli	ngs MD 2155
19	2	0a. Method of Disposition 1 Burial 2 □ Cremation 3 Comparison 3	Removel from State	como	of Disposition (A ery, crematory o	Vame of or other plac	e)	Date	20c. Loc	ation - Ci	ity or Town, State
nu's		4 □ Donation 5 □ Other (Speci			awn Mem	orial	Gardens	02/06	Lav	ale 1	MD
any Injury or once.	2	1. Signature of Funeral Service Lice	nsee		22. Name	and Addras	s of Facility				ш
any Ir) w	1 , 1	7			i Funera		P.A.	,	
	15	Oa. Part1. Enter the disease, or con	polications that cause	d the death. De	Cun	nberla	and MD 21	L502_	arroet		Approximete
ician		shock, or heart failure. List only	one ceuse on each i	ine.		,,,,,	9,	o on roop natory t			Interval Between Onset and Deet
dical	1	mmediate Cause (Final									
niner	d	lisease or condition esulting in death)	a. ACUTE R	ESPIRAT	ORY FAI	LURE					2 HOURS
e					consequence of	of):					
nin nin			b. PNEUMON	IA							10 DAYS
s the buriel-transit	S	sequentially list conditions, any, leading to immediate ause. Enter Underlying		Dua to (or as	consequence of	of):					
		ause (Disease or injury	C								
s the bu	tr ri	nat initieted events esulting in death) Last		Due to (or as a	consequence o	f):					
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deteched for use a	P	art il. Other aignificant conditiona	contributing to death t	out not resulting	in the underlying	g cause give	en in Part I.	23b. Did	tobacco u	ise contr	ibute to the cause of de
Phy								1	Yes 2	No 3	Probably 4 Unk
	. -										
b be									s an autops ormed?	Sy :	 Were autopsy finding available prior to
b be								po			completion of cause of death?
b be	-							10	Yes 2	No	1 ☐ Yes 2 ₹ No
ge 2 should be o	-								100 - 2	20110	12 100 220110
page 2 should be d		5. Was case referred to medical					OF Place of De	ath (Charle ank	1		
actor, page 2 should be d	2	5. Was case referred to medical axaminer?	Hospital:	ant 20 50%	hutnetiant 201	DOA Othe	26. Place of De			DO# -	(0
and director, page 2 should be director, page 2 should be director.	2		1 & Inpati	ent 2 ER/C			er: 4□ Nursing H	fome 5 ☐ Res	idence 6		
ral director, page 2 should be d	2	axaminer? 1 ☐ Yes 2 ☑ No 7. Mannar of Death 1 ☑ Neture: 5 ☐ Pending	28a. Data of Inju (Month, Da	ury 28b	Time of Injury	28c. Injury Work	er: 4□ Nursing F at		idence 6		
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DHMH 16 Rev 6/95

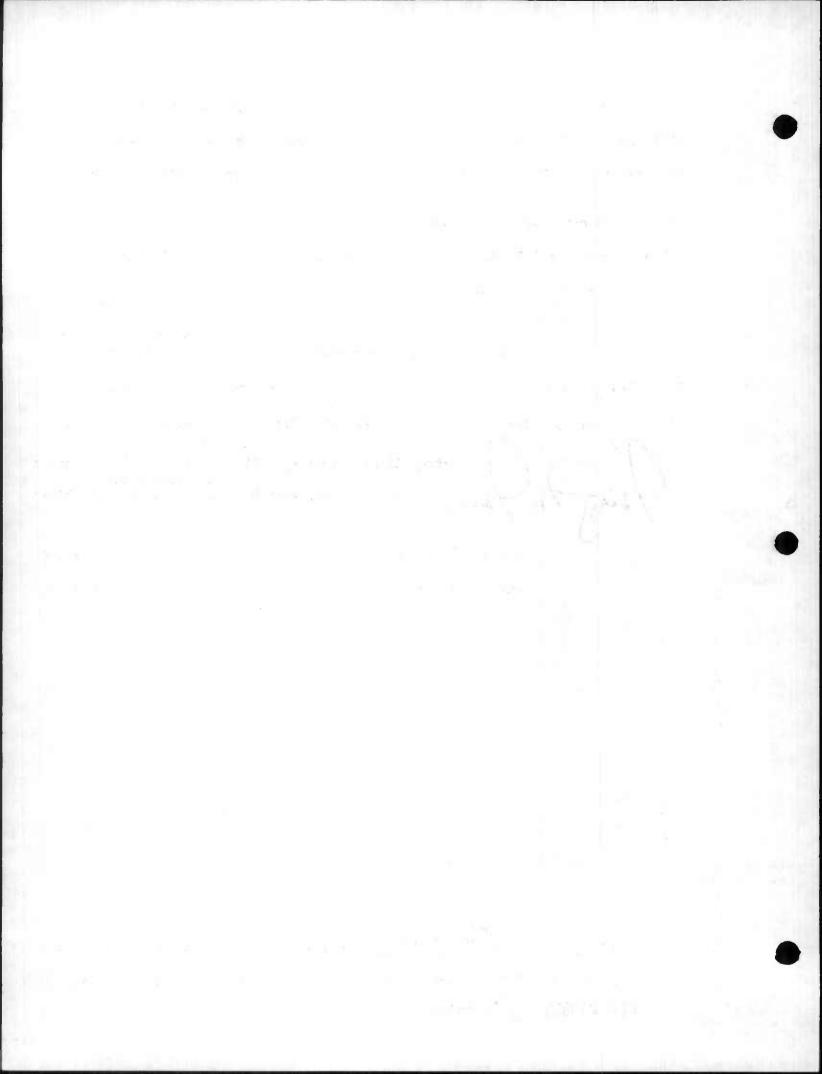
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State of Maryland / Department of Health and Mental Hygiene 9

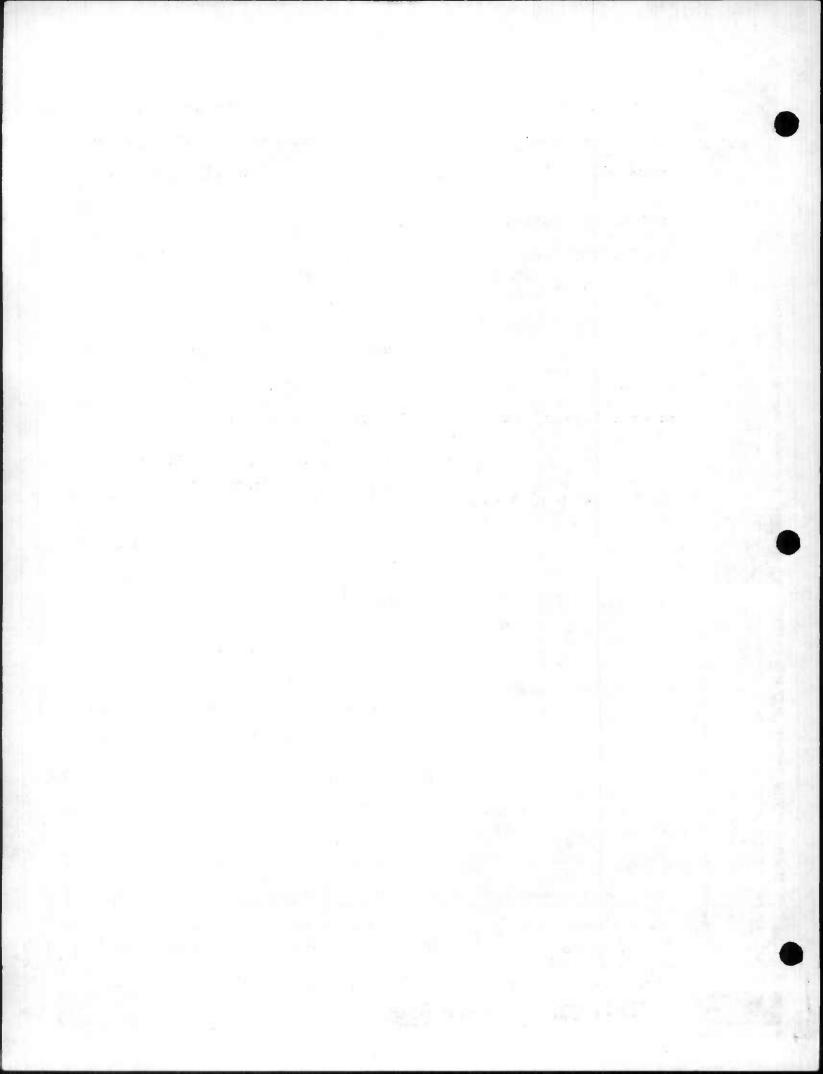
					Cer	tificate of	Death		Reg. No.	1014	0023
		1. Decedent's Name (First, Middle,	Last)					2. Dete of D Month	eeth	Veer	3. Time of Death
Physic /Med		FEI-PONG	LEE					FEBRUA	RY 12,	Year 1998	10:32 A.M
Exami		4a. Facility Nama (If not institution,	give street and numbar)				4b. City, Tow	m, or Location of Dea	T	y of Death	
		17313 FOUNDERS N	ILL DRIVE				ROCK	VILLE	MONT	GOME	RY
Funeral Director		5. Social Security Number 463-43-4116 Usual Residence of Decedent	5. Sex 7. Ag 1 M 2 □ F	ge (In yrs. lasi 99	birthday) Yrs.	if Under 1 Year Months Days	If Under 2 Hours	Hrs. 8. Date of B Min. (Month, D Jan 24	rth ay, Year) , 1899		placa (State or Foreign ntry) ina
with the Maryland a or 28a-f show Le notified at		10a. State 10b. County		10c. City, T	own or Lo	cation					10d. fnslde City Limits
Mar	ţo	MD Montgo	omery	Rock	ville						1 ☐ Yes 2 ☐ No
or 28	je je	10e. Streef and Number	•			10f. Zip Code			10g. Citizen of	Whaf Cou	nfry?
23a c	a o	17313 Founders M	Mill Drive			2085	5		United	Sta	tes
efter dea or items	by Funeral Director	11. Marifal Status 1 Never Married Marrie 3 Widowed 4 Divorced	12. Was Decedant Armed Forces? d 1 Yes 2 X If Yes, Give Yaar or Datas:			Vas Decedent of H i Yes, specify Cub □ Yes 2∑ No	tispanic Origi an, Mexican, Specify:	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Ra Ble Speci	ck, White, fv:	can Indian, etc.
72 ho	ted	15. Decedent's (Specify only highest	Education	1	6a. Deced	lent's Usual Occup kind of work dona	pation	of working	16b. Kind of E		
Mal ylallia & IX I 3-0000 d 2 should be filed within 72 hours ef th end Mental Hyglene. 7 Is marked other than "natural", or traumatic event, its Modical Exam	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	nistrato	d)	or working	Federal of Ta		ernment
other the comment of	Be C	17. Fathar's Name (First, Middle, Li	ast)	·			18. Mother	's Name (First, Middle	e, Meiden Surna	me)	
Alente Alente rked tice	To	Hwa - Tsu Le	ee				(Ur	ıknown)		Lou	
sho ond h	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street	and Number	or Rurel Route Num	per, City or Town	, State, Zij	Code)
and 2 eelth 27 I		Ni - Chi Lee ,	wife		17313	Founder	s Mill	Drive, R	ockville	, MD	20855
Datumore, Maryland ZIZID-002 permit. Pages 1 end 2 should be filled within 72 hours Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", any injury or other traumatic event, the Modest Examples.		20a. Method en Disposition 1 Berrial 2 Dicremation 3 4 Document 5 Dotter (Special Control of Cont				sition (Name of natory or other pla tan Crem		Feb. 19	20c. Location		own, State Virginia
permit. F Department Importan		21. Signature of Funeral Service Li	to the		22	. Name and Addre	ess of Facility		Funeral	Hom	e
Physician		23a. Perty. Enter the disease, or cashes, or heart failure. Ust of	omplications that caused nly one ceuse on each li	d fhe death. I	Do not ente	er the mode of dyl	ng, such as c	ardiac or respiratory	arrest,		Approximata Intervel Between Onset and Death
/Medical Examiner		Immediate Causa (Final disease or condition resulting in death)	a. CHRONIC								20 YEARS
	ē		ARTERIO	Due to (or as	· ·	uenca ot):				i i	OO VEARC
cate be executed physician and sthe buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events	b. ARTERIO	Due to (or as		uence of):					30 YEARS
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hat the death certing by the attending detached for use of Trancis N	Physician/		u.								
d by the a setached in Tanc	ysic	Part fl. Other significant conditions	s contributing fo death b	uf nof rasulfin	g in the ur	derlying cause giv	ven in Part I.	23b. Dic	tobecco uae co	ontribute t	o the cause of death?
ires that the de signed by the ad be detached	by Ph					_		1	Yes 20 No	3 ☐ Pro	babiy 4 ☐ Unknown
s been 2 shoul	Completed								en eutopsy ormed?	av	rere eutopsy findings railable prior to empletion of causa death?
The la ate ha page by	Con							1 🗆	Yes 2∑No	11	☐ Yes 2☐ No
icien: The certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Plece	of Deeth (Check only	one)		
Physicien: this certific ral director,	To	1 N Yes 2 No	Hospital: 1 ☐ Inpatie	enf 2 ER	Outpetien	3□ DOA Oth	ner: 4 □ Nurs	sing Home 5 TRes	ldence 6 □Ot	har (Speci	fy)
or Attending Pheter death. Director: After the in by the funeral Sed 2/12		27. Menner of Deeth 1 ☑ Netural 5 ☐ Pending 2 ☐ Accident investiga	220	y Year) 28	b. Time of Injury	28c. Injui Wor M 1 □	yat rk? Yes 2 □ N		how injury occu	rred	
lal or Attending is efter death. I Director: After ed in by the fune as ed 2/	Certification:	3 ☐ Suicida 6 ☐ Could no 4 ☐ Homicide determin		ury - At homa c. (Specify)	, farm, stre	eef, factory, office			(Street and Num wn, State)	ber or Run	al Route Number,
To the Hospital or Att within 24 hours efter d To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminer: On the basis of and manner sta	f examination	dge, death and/or inv	occurred at the tir estigation, in my o	me, date and opinion, death	place, end due to the occurred et the time	ceuse(s) and m , date and place	enner as s end due t	stated. o the cause(s)
vithii To the	Y	29b. Signatura and titla of certifier	1	1	1	29c. Licans	a number		29d. Date sign	ed (Month,	Day, Year)
2 eare		- Sav	To	12	a	D133	39		Februar	y 13	, 1998
V Clea		30. Name and address of person with T. Chanchien, M.				Print)		Berwyn H			
Sta Regist	-	31. Date filed (Month, Day, Year)	A fine	Sonatur		6					

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Neme (First, Middl	le, Last)						2. Dete of De			3. Time of De
Physiciar Medica/	_	Albert Litm	an						Februa	Dey arv 9.1	Yeer 998	11:5
Examine	-	4a. Fecility Neme (If not institution	n, give street end nu	ımber)			4b. C	ity, Town, or I	Location of Deet			T. T. J.
		Suburban Hos	pital				Ве	thesda	а	Montg		У
uneral irector		5. Sociel Security Number 578-22-9031	6. Sex 11 M 2 ☐ F		rs. last birthdey) 7 2 Yrs.	Months		Under 24 Hrs. lours Min.	(Month, De		9. Birthple	ece (Stete or Fary) York
E	- 1-	Usual Residence of Decedent 10a. Stete 10b. County		10c.	City, Town or Lo	ocation					10	d. Inside City L
notified at		Maryland Mon										1X Yes 2
be notified	Lec	10e, Street end Number	Lgomery	F	Potomac	10f. Zip	Code			10g. Citizen of V	What Count	m/2
28 0	5	8712 Liberty	Lane				854			U.S.A		
if, or items 23s Examiner must		11. Marital Status 1 Never Merried 2 Marr 3 Widowed 4 Divorced	12. Wes Dec Armed For 1 XYes	2 No		Was Decede If Yes, speci			pecify Yes or No o Ricen, etc.)	- 14. Rece	e - Americe k, White, e	
			t's Education	76(65.	16e. Dece	dent's Usual	I Occupation	<u> </u>		16b. Kind of Bu	isiness/Indi	ustry
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the M	5	Comonicary/Secondary (0-12)	College (1-401 5+)		rmaci				Self-E	mp1o	yed
to a	2	17. Fether's Neme (First, Middle,	Last)				18.	Mother's Nen	ne (First, Middle	, Malden Surnem	e)	
atic ev	2	David Litman					(Celia	Franke	21		
ls m		19a. Informent's Neme/Reletions								er, City or Town,	Stete, Zip (Code)
n 27		Jeanette Lit	nan/Wife		8712 Place of Dispo cemetery, crem			Lane	Potoma	ac, MD	208	54
Important: any injury snice.	-	4 Donation 5 Other (S		e de	idean M	2. Name end	Address of Pears	Fecility Son Fu	neral	Homes Lington		
edical		Immediate Cause (Finel disease or condition	P)			D.	10.0	or respiratory e			Approximete Interval Betwee Onset end Dee
miner vel-trensit		Immediate-Cause (Finel diseese or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet Initiated events resulting in deeth) Lest	o	Due to	(or es a consequence of consequence	quence of):	de fre	line	ma			Interval Betwee
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State of Maryland / Department of Health and Mental Hygiene

			*			Cer	tificate o	f Death			Reg. No.	0 1	00.	31
	Division		1. Decedent's Name (First, Middle, Las	st)						2. Data of Da	ath	V	3. Time	of Death
	Physic /Medi		Dwight D. Locke							Month Februa	ry 9, 1	Year 1998	12:0	07AM
Ä	Exami	ner	4a. Facility Nama (If not Institution, give	e straet and number)				4b. City, To	wn, or Lo	cation of Death	4c. Coun	ty of Death		
L	N. Turk		9520 Old Georgetov					Bethe			Monts	gomery	7	
3	Funeral Director		212-20-1488	ax DŽM 2□F	90	Yrs.	if Undar 1 Ya. Months Day		Min.	8. Date of Bird (Month, Da April 2		Cou	ntry)	setts
	and *		Usual Residence of Dacedent 10a. State 10b. County		10c. City, To	own or Lo	cation						10d Insida	City Limits
	Mary and sho	tor	Maryland Montgome	erv	Bethe	sda						·		es 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code	•			10g. Citizen o	f What Cou	ntry?	
	th wil		9520 Old Georgeto	own Road			2081	4			United	State	es	
	r dea	Funerai	11. Marital Status	12. Was Dacedent Armed Forcas?	Ever in U,S.	13. V	Vas Decedant of Yes, specify Co	f Hispanic Orig	gin? (Spe	cify Yes or No-	14. Ra	ace - Americack, Whita,		1
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mantal Hyglena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mooical Examinat must be included at once.	by	1 ☐ Never Married 2 ☐ Married 3XXWidowed 4 ☐ Divorced	XXYas 2 ☐ I If Yes, Give Yaar or Datas:	NoWorld	. 1	□Yes 2X0N		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Spec			
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re,	Hear Hear other		20e. Method of Disposition	LI/Daugitte	COL DI	of Diago	- Winn / Min				20c. Location			
altimore,	ages ent of rt: If if		1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify		ceme	tery, crem	natory or other p	Feb.	. 13,	1998				
<u>=</u>	ortar		21. Signature of Funeral Service Licen		Georg	e wa	shingto Name and Add	n Cemet dress of Facility	vRob <i>e</i>		Adelph: Pumphre			
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	and the same		23a. Part1. Enter the disaasa, or come	plications that bused	the death. De	o not ente	thesda,	Maryla Ving. such as	and cardiac o	20814- r raspiratory ar	3501 rest.	- 1	Approxim	nate
	Physician		shock, or heart failure. List only o	one ceuse on each lie	ne.							1	Interval B Onsat an	Between
	/Medical		Immediate Causa (Final disease or condition	Maroca	rdial	Infa	retion					i	Sudd	an
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<u>a</u>	ysician: This certificate director, par	Be C	25. Was case referred to medical					26. Place	of Death	(Check only o				24
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	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Da)	y Year) 28b	Time of	28c. in	jury at		8d. Describe h				
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DIVISION	frect irect in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuliding, etc	ury - At home, c. (Specify)	farm, stre	et, factory, offic	е	2	8f. Location (S City or Tow		nber or Rura	I/ Route Nu	ımber,
2	urs a urs a prei Dilled		20.0.11											
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: complately filled in by the	Medical	29a. Certifier (Check on Decirion Medical Exami	ines: On the basis of end manner sta	examinetion a	ge, death and/or inve	occurred at the estigetion, in my	time, date end opinion, deat	d piece, a h occurre	nd due to the o d at the time, o	ause(s) end n dete end placa	nenner es s , and due to	tated. the cause	a(s)
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Completed by Physician/M				_ 0													
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OU	27. Menn	er of Deeth aturei	5 Pend	ing	28a. Dete (Mont	of tnjury h, Dey Yeer)	28b. Time Injury		28c. Injur Wor			28d. Describe	e now injui	y occur	190		
Sati	2 🗆 A	ccident	inves	tigation				М		Yes 2	I No						
tific		uicida łomicide	6 Could deter	not be mined	28e. Place buildi	of Injury - At h	ome, farm,	street, facto	ory, offica			28f. Location City or T	(Street er	nd Numb e)	er or Rure	el Routa Number,	
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edical Certification:	29e. Cert					best of my kno											
9	(Che	ck only	2 Medica	(Examiner:		ests ot exemina ner steted.	etion end/or	Investigetio	n, in my o	pinion, de	eth occur	red et the time	e, date end	d piece,	and due to	o the ceuse(s)	
Me	29b. Sign	eture end	of cartiti	er				2	9c. Licens	a number			29d. Da	ite signe	d (Month,	Day, Yaar)	
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		1	avie	1011	1000	101	U				_		100		7 17	,1998	_

9410 old Georgetown Road

Betherda Md. 20814

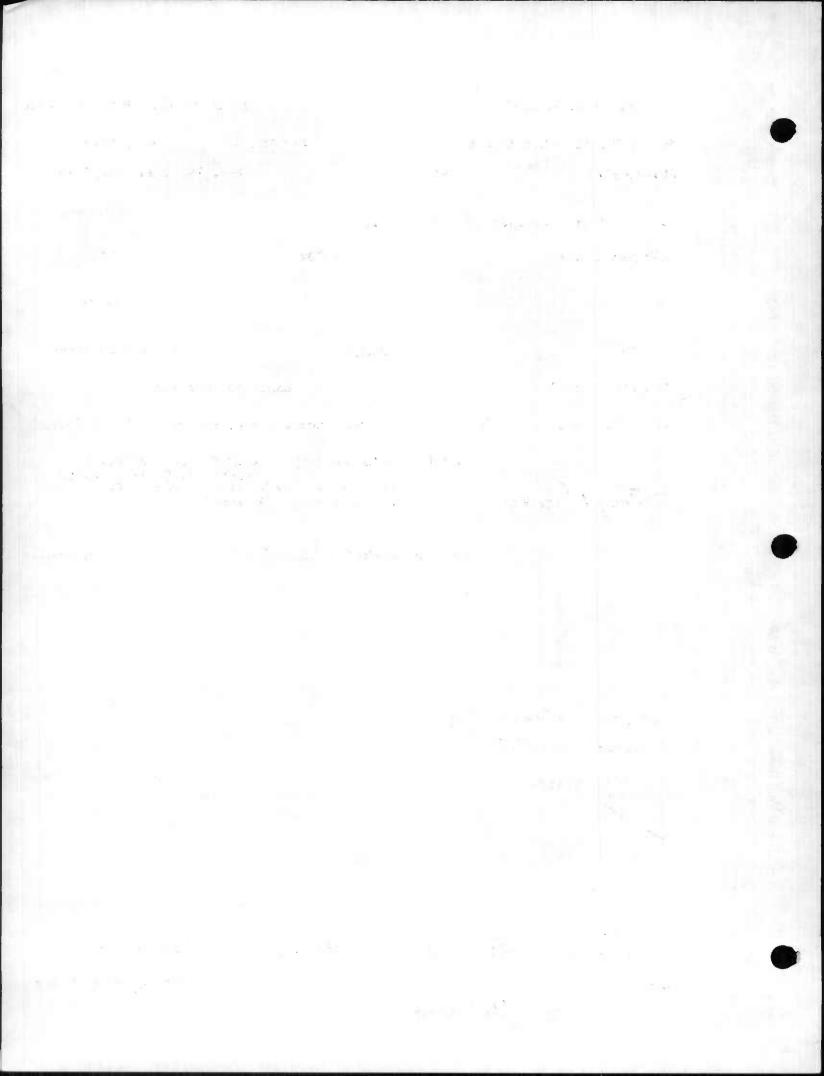
State Registrar 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

David A. Blass no 9410 old Geor

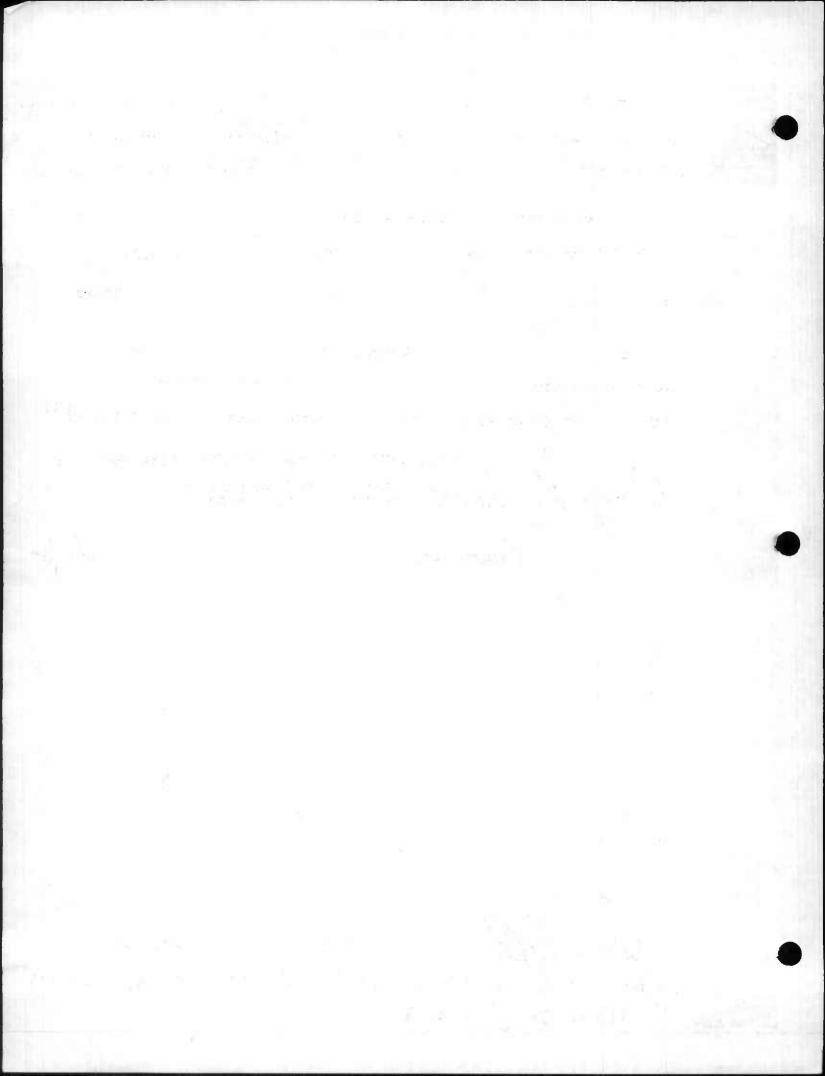
31. Date tiled (Month, Dey, Year)

Progintaria Signature

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	Physic		1. Decedant's Nama (Fin	rst, Middla, Lasi ANOR		LYNCH				2. Data of De Month Feb		Year 998	3. Time of Death 9:50 Am
	/Medi Examir		4a. Facility Nama (If not Mariner		street and num	,	Manor			Location of Daatt	4c. County	of Death	
	Funeral Director		5. Social Sacurity Number 241-82-34	er 6. Sa		. Aga (In yrs. la		If Under 1 Yaar Months Days	Kensin If Under 24 Hrs Hours Min	8. Data of Birt		9. Birthp Coun N.	lace (Stata or Foreign try) Carolina
			Usual Rasidance of Deca	edant . County			Town or Loca	ation					0d. Inside City Limits
	vith the Marylen or 28a-f ehow be notified a	tor	- A. A. C.	Montgo	mery		cookev						1 X Yas 2 No
	with the	Director	10e. Street and Number	Nlnang	lov. In	20		10f. Zip Coda	2.2		10g. Citizan of		try?
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	To the Hospital within 24 hours of the Funeral completely filled	edicai C	29a. Certifier (Check only one)	Cartifying Phys Medical Examin	sician: To the be nar: On the bas and manne	s of axamination	ledge, deeth o on and/or inva	occurred at tha tin stigation, in my o	na, data and place plnion, death occ	e, and dua to tha urred et the time,	cause(s) and ma dete end placa,	annar as st and dua to	ated. tha causa(s)
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	Sta Registr	_	FEB		8	June S Signati	an Maryl	عالم					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Barbara Lambert Ann February 15, 1998 2:20 PM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Doctors Community Hospital Prince Georges Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 201 F Days 214-36-5354 Yrs. Director 58 Maryland Usual Residence of Decedent the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, fire Medical Examinat must be inclifted at 1 Yes 2 No Director Maryland Prince George's <u>Greenbelt</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 7066 Hanover Parkway, #C-1 20770 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ◯ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Biack, White, etc. 1 ☐ Never Merried 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or I any Injury or other traumatic event. 1 ☐ Yes 2 ☐ No Specify: Specify: by 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Care Management Elementary/Secondery (0-12) College (1-4or 5+) Resources Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Randolph Lambert Ann Elizabeth Bryan 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jennifer A. Dulin 15th Street, NE, (daughter) Everett, WA 20e. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2-20-98 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Carcinoma of Pancreas with Metastasis to Liver Examiner Due to (or as a consequence of): Examiner physiclen and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as e consequenca of): 980 0 signed by the a Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? Records, P.O. 3 □ Probably 4 ☑ Unknown 1 Yes 2 No þ should should Completed 24a. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? page 2 s 1 Des 2□ No certificeta Division of Vital the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifics mpletaly filled in by the funeral director, I 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completaly filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner es steted. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 14.0

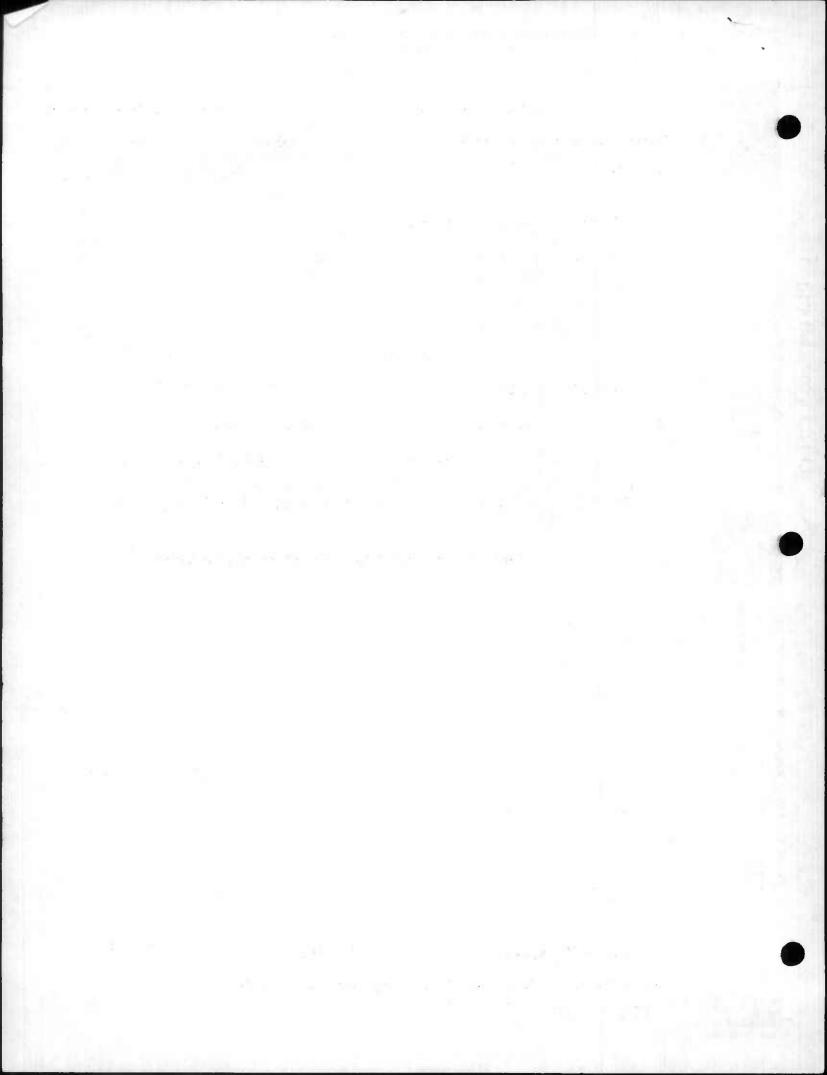
State Registrar

James Elliott, MD

FEB 20

31. Date filed (Month, Day, Year)

8118 Good Luck Road, Lanham, MD 32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death Month **Physician** PEGGY 1:00 PM LOIBEL 08 1998 FEBRUARY /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** CENTER FREDERICK HEALTH CARE FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1□M 2√F 73 Director Feb. 5,1925 212-24-0132 West Virginia Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD ALLEGANY Yes 2 No Director CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 itams 23a 884 SPERRY TERRACE 21502 Funeral U.S.A.

14. Rece - American Indian,
Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 72 hours efter 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: WHITE by 3 ☐ Widowed 4 ☑ Divorcad "natural", Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within tent of Health and Mentel Hygiena. At: If Itam 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 SALES CLERK RETAIL STORE 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) AUSTIN SCHWARTZ VIVIAN E. DUCKWORTH 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: if Itam 27 is any Injury or other trau VICTORIA E. LOIBEL/DAUGHTER 1924 BEDFORD STREET, CUMBERLAND, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY CUMBERLAND, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 23a. Pert 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. COPD Ventilitar Depund 15 year **Physiclan** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner transit. that the death certificate be axecuted Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequença of). physician e Box 68760. Physician/Medicai Due to (or as e consequence of): 88 attending p P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? the 2 1 Yes 2 No 3 Probably 4 Unknown Anemia signed l Records, A 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? page 2 2 No certificata 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 MNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date end placa, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, end due to the ceuse(s) end manner stated. 29e. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Yeer) D21944 MY

State Registrar



Frederick, nd. 2170

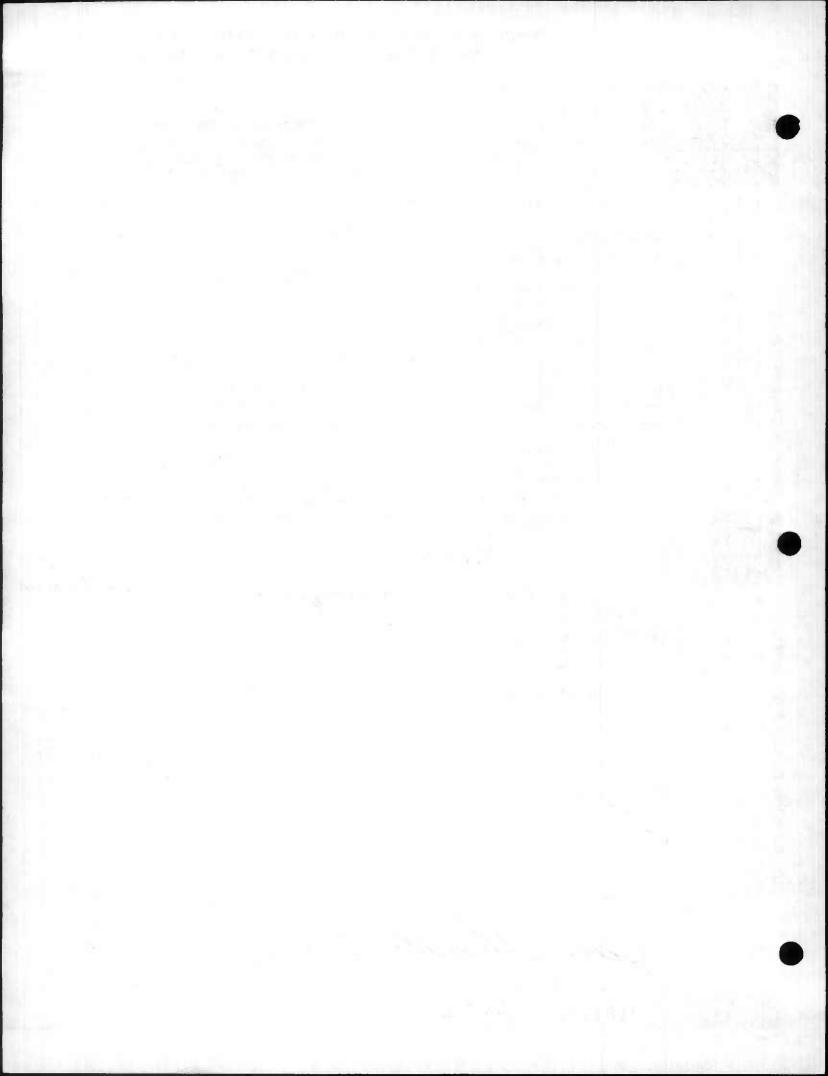
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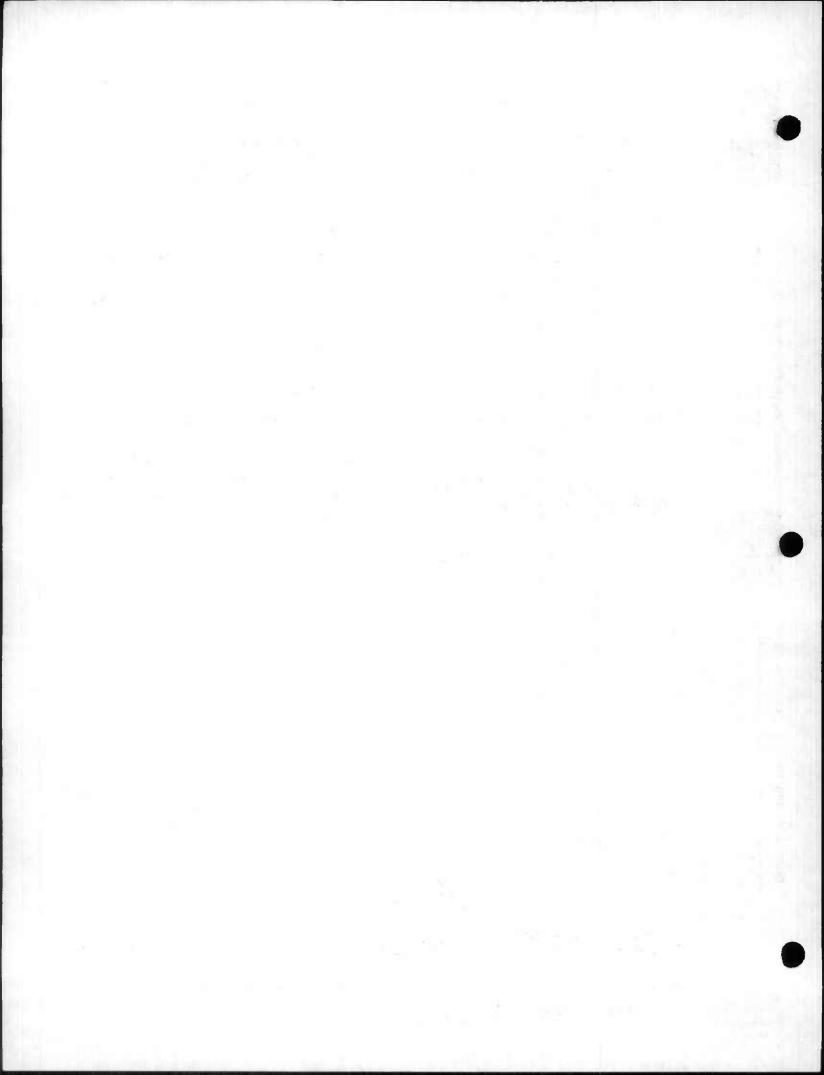
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Deeth **Physician** Month Martha Henderson Lacev February 13, 1998 9:28 PM /Medical 4e. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner Manor Care Health Services Chevy Chase If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day), Year Min. April 28, Montgomery 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) **Funeral** Birthplaca (State or Foreign Country) 1□M 210 F 82 Yrs. 1915 Massachusetts Director 577-62-8163 Usual Rasidance of Deceden the Marylend 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Modical Exprener must be notified at 1 □XYas 2 □ No Director N/A N/A Washington, DC 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 3415 Porter Street, NW United States 20016 Funeral 12. Wes Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Datas: Wes Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. filed within 72 hours effer 1 □ Navar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: P 3℃Widowad 4 Divorced "natural", White Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedant's Education 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, the Mental pane. (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Altar Guild Head Religion 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be John W. Henderson Patience B. Ballentine 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John H. Lacey P. O. Box 3329, Shepherdstown, WV (son) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) 2-15-98 Beltsville, Maryland Chesapeake Crematory 21. Signatura of Funarel Service Licensee 22. Nama and Address of Fecility
Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disease, or compilcations that caused the death. Do not anter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immadiata Cause (Final Dummia diseesa or condition rasulting in daath) Examiner Examiner buriel-transit Sequentially list conditions, if eny, laading to immediata causa. Enter Underlying Causa (Disaasa or injury that Initiated events rasulting in deeth) Last pue physician Physician/Medical the Due to (or as a consaquance of) 80 ettending esn jo signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? page 2 1 ☐ Yas 21 No 1 ☐ Yes 2 ☐ No this certificete Division of Vital 25. Was casa refarred to medical Be 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Deta of Injury (Month, Day Year) 27. Mennagof Death 28d. Dascribe how injury occurred 28b. Time of Certification: 28c. Injury at Work? After 1 Natural 5 Panding Invastigation death. 1 ☐ Yas 2 ☐ No To the Hospital or Attendition within 24 hours efter death.

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2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner a 29a. Certifia 29b. Signature end titla of certifian 29c. Licensa number 29d. Data signed (Month, Dev. Year) ad causa of death (Itam 23a) (Type, Print) lunc TAMES Month, Day, Year) FEB 17 1998 31. Date filed (Month 32 Registrar's Signature State Registrar

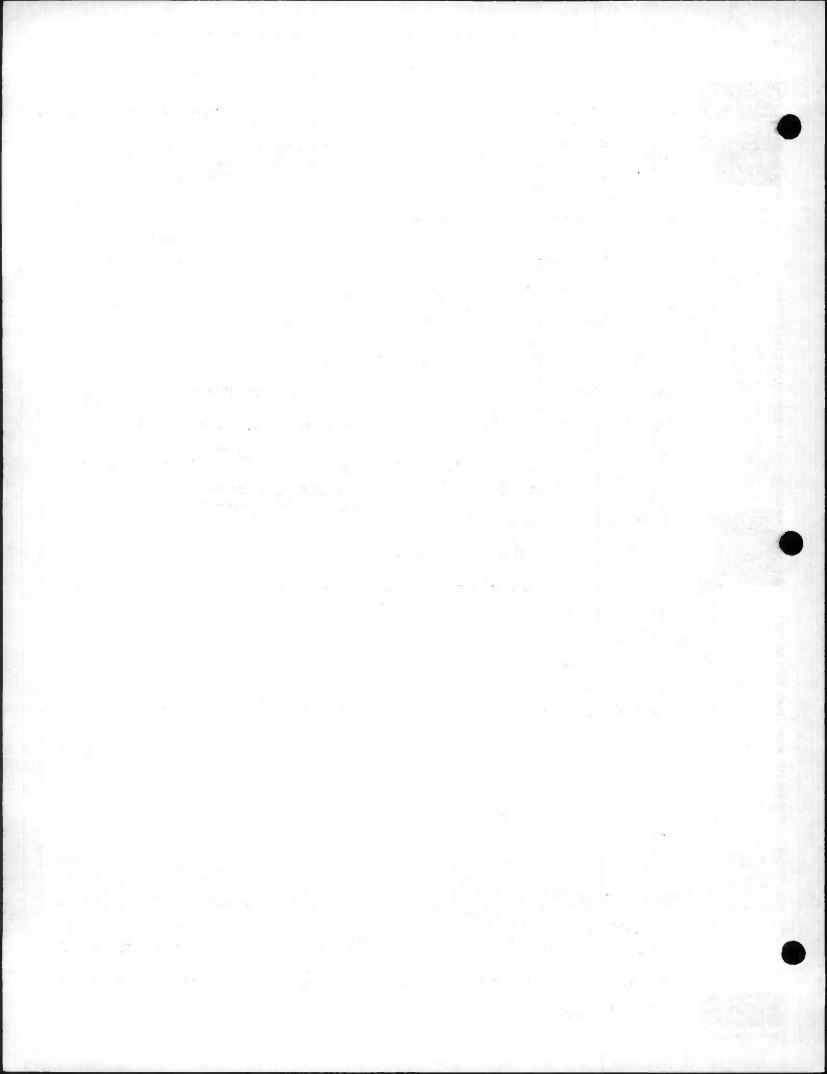


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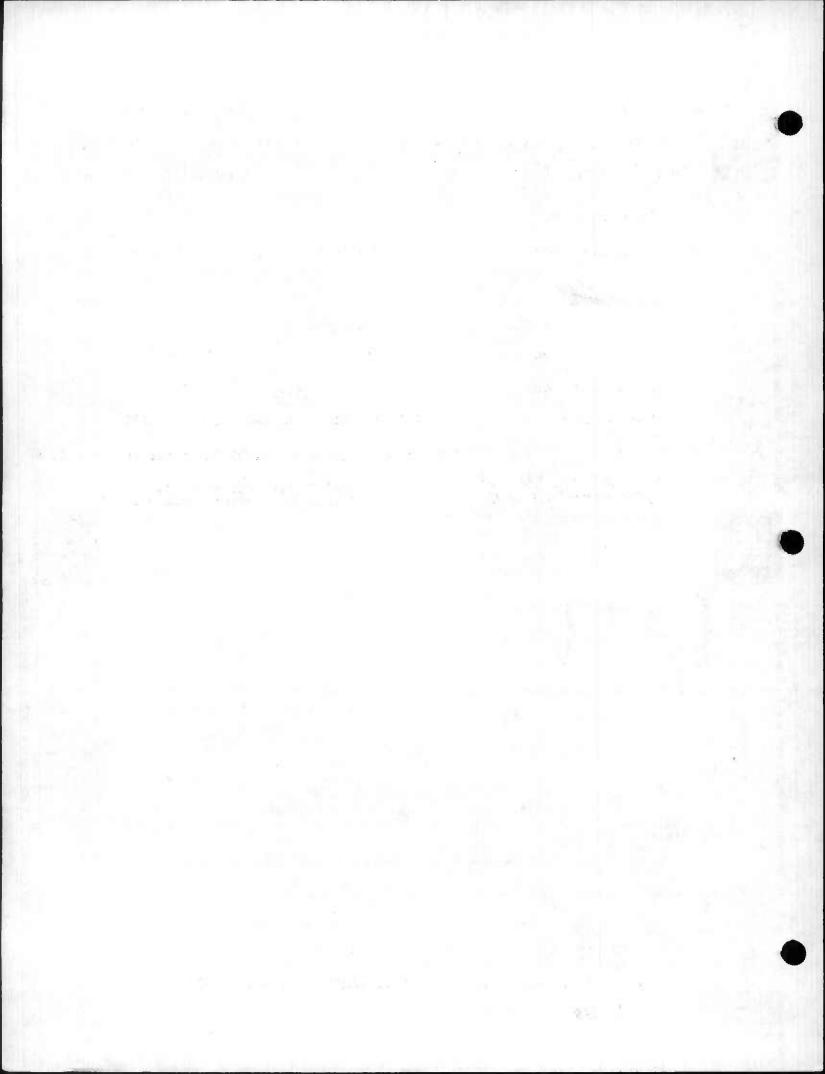
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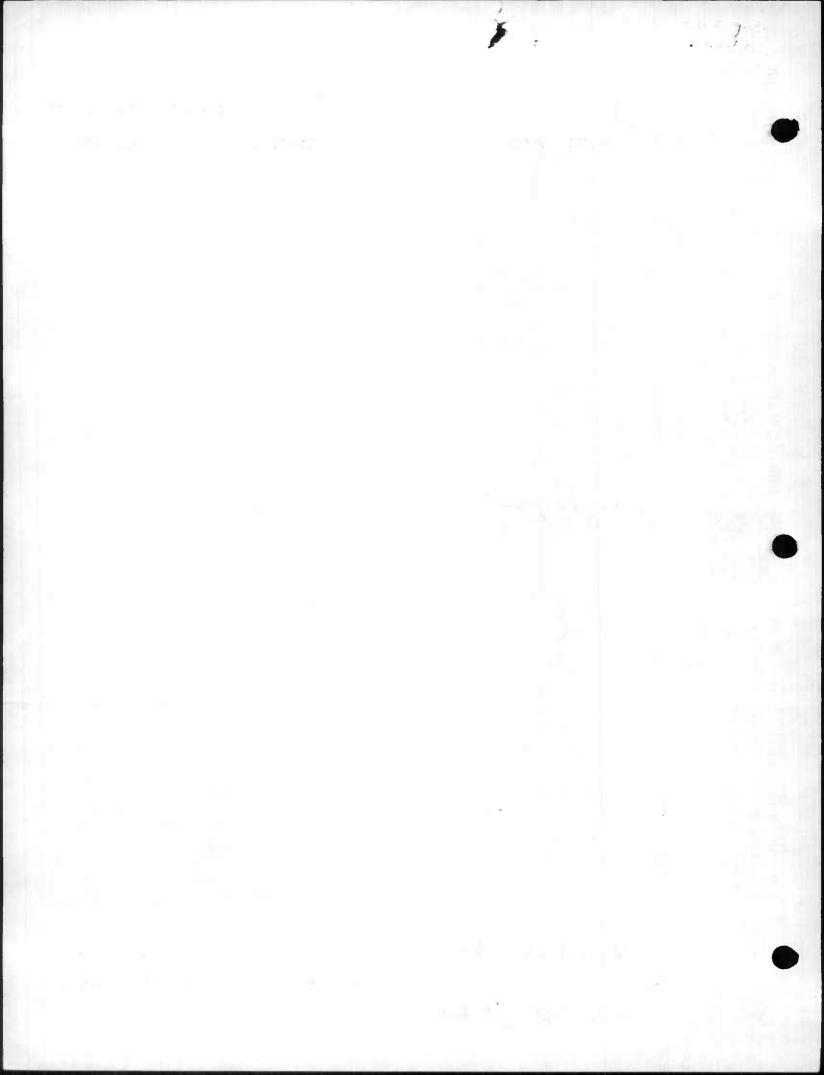
MARYDRUM

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30, Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

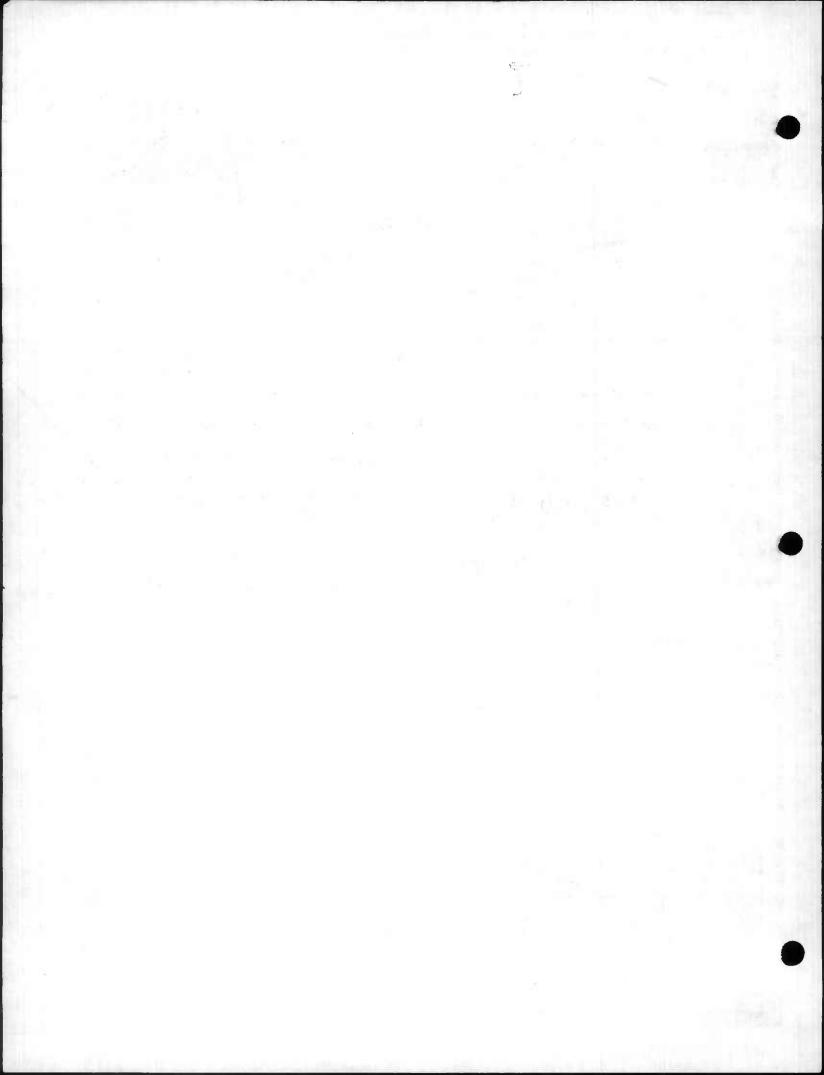
111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signeture

O.C.M.E.



State of Maryland / Department of Health and Mental Hygiene

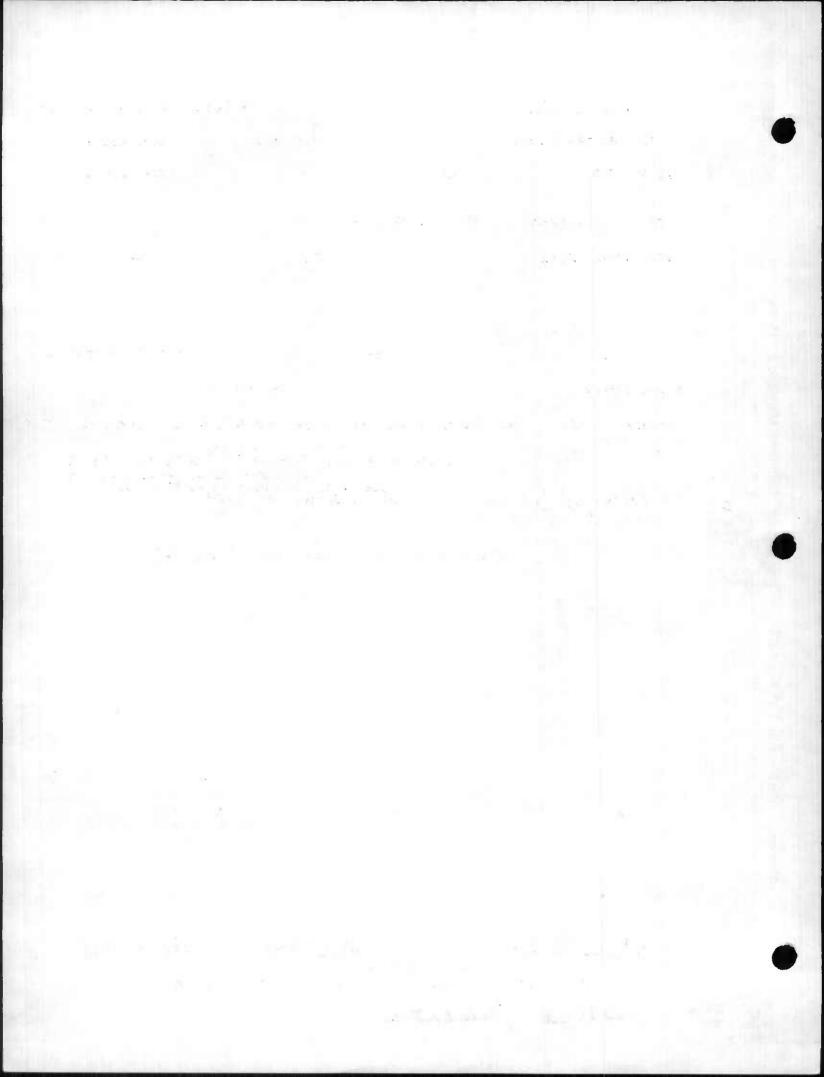
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		Holy Cross	Hos	pital				Í	Silver S	pring	Mo	ntgome	rv
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dand		10e. State 10b. Cour	nty		10c. Ci	ty, Town or L	ocation					1	I0d. fnside City Limits
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ges 1 and 2 should be filed within 72 hours efter deeth with the Maryland it of Health end Menial Hygiene. If Item 27 is marked other than "natural", or items 23s or 23s-1 show or other traumatic event, the Med call Examiner must be notified at	by Funeral	1 ☐ Never Merried 2 ☐ N		Armed Forces 1 ☐ Yes 2X If Yes, Give Yeer or Dates	s? JeNo		If Yes, spe	cify Cut	oen, Mexican, Pue	nto Rican, etc.)	В	leck, White, city: Whi	etc.
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2 sho end A ie me		19e. Informent's Neme/Reletic				19b. Melli	ing Addres	s (Stree	t end Number or F		er, City or Tow	m, Stete, Zip	Code)
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in the market		21. Signature of Funeral Servi			FUL	t Line				2/18/98			
pemit. Page Department of Important: If any injury or page.		1 Least	Wh.	loclor		11	800 1	lew	Hampshir	ines-Rin e Ave. S	aldi Fu ilver S	ineral Spring	Home, Inc
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To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical (29e. Certifier 1 Certification 1 Certification 2 Medication 1 Certification ing Phy al Exam	ysician: To the bes	of examine	wiedge, deat tion end/or in	h occurred vestigetlor	et the t	ime, date end pled opinion, death occ	ea, end due to the curred et the time,	cause(s) end i	menner es s e, and due to	teted. the ceuse(s)	
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1		30 Name and address of person	rylwrid o	completed cause of	deeth (Item	п 23е) (Туре,	Print)		. 10	1	Poll	00/	mi
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Sta	ite	31. Dete filed (Month Day, Ye	100		trer's Signe								/



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 16, 1998 7:50 AM Mary Lee McGinley /Medicai 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4924 Adrian Street Rockville Montgomery H Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Yeer)
July 27, 19 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) **Funeral** Months 1 M 2 F Yrs. 578-40-7795 70 1927 Virginia **Director** Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturaf", or items 23a or 28a4 ehov any injury or other treumatic event, tra Medical Examinat Inval be notified as 1 ☐ Yes ZX No Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4924 Adrian Street 20853 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 ™ Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 11 Secretary 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Keith Godsey Leah Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara McGinley 8 Russell Avenue, Apt.304, Gaithersburg, MD 20879 (daughter) 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State /25/98 Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 22. Name and Address of Facility Francis J. Collins Funeral 21 Signature of Funeral Servica Licenses 500 University Blvd. West Home, Inc. Silver Spring, MD 20901 tures 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** METACTATIC CARCINOMA OF TONGUE /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ettending physician end for use es the buriel-transit that the death certificate be executed Sequentially list conditions, if amy, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in descriptions) Due to (or as a consequence of): Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? per per P.O. been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy hes 1 Yes 2 □ No 1 ☐ Yes 2 No certificate Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident or Attendential or Attendential of the Office of the Offic 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Funeral Hospital 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. WILLIAM DAMUT, GEORGETOWN UNIVERSITY HOSPITAL 31. Date filed (Month, Day, Year) FEB 18 193 32 Registrar's Signature State Registra



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1, Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey 12, Year February 12, 1998 Alfred V.C. Meyer 1850 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 3402 Chiswick Ct Silver Spring Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Deys Months Hours 1X M 2□ F 81 Oct 20, 1916 011-20-6700 Massachusetts Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10e Stete 10b. County 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20906 3402 Chiswick Ct USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Yeer or Detes: WWII Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Stetus Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Tyes 2 NO No Specify Specify 3 ₩ Widowed 4 Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'e Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Geologist Sciences 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Alfred Hunter Meyer Antoinette Van Cleve 19b. Mailing Address (Streat end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 1401 Blair Mill Rd, #318, Silver Spring, MD 20910 John Meyer/Son 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Rock Creek Cemetery Feb 17 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Hines-Rinaldi Funeral Home Ollan 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Pert1. Enter the distance or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final Cardiac Arrhytmia Minutes disease or condition resulting in deeth) Due to (or es a consequence of) Hypoxemic Heart Disease Years Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequenca of): 5 Years Eosinophilic Granuloma Due to (or es e consequenca of) 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Arterial Hypertension 24b. Were eutopsy findings eveilable prior to 24a. Was en eutopsy performed? Asthma-Chronic completion of cause of death? 1 Tyes 2 TXNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) exeminer? 1 X Yes 2 □ No niner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es steted 2 Medical Examinar: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, and due to the ceuse(s) end menner stated.

> 29c. License number D07067

5625 Bradley Blvd, Bethesda, MD 20814

29d. Date signed (Month, Dey, Year)

February 12, 1998

To the Hospital or within 24 hours eff To the Funeral Di completely filled in

State Registrar

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Examiner

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Certification:

Medical

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Director

filed within 72 hours effer death with the Maryland Hygiene. Ther than "natural", or frems 23a or 28=4 show ant, its Woods Experience must be notified at

permit. Pages 1 end 2 should be filed wir Department of Health and Mental Hygien, Important: If Item 27 Ia marked other tha any filury or other traumatic event, tra-once.

Physician /Medical

Examiner

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al or Attending Physician: The setter death.
Il Director: After this certificated in by the funeral director, pr

that the death certificete be executed

The law requires

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0020

31. Date filed (Month, Dey, Year) FEB 17199

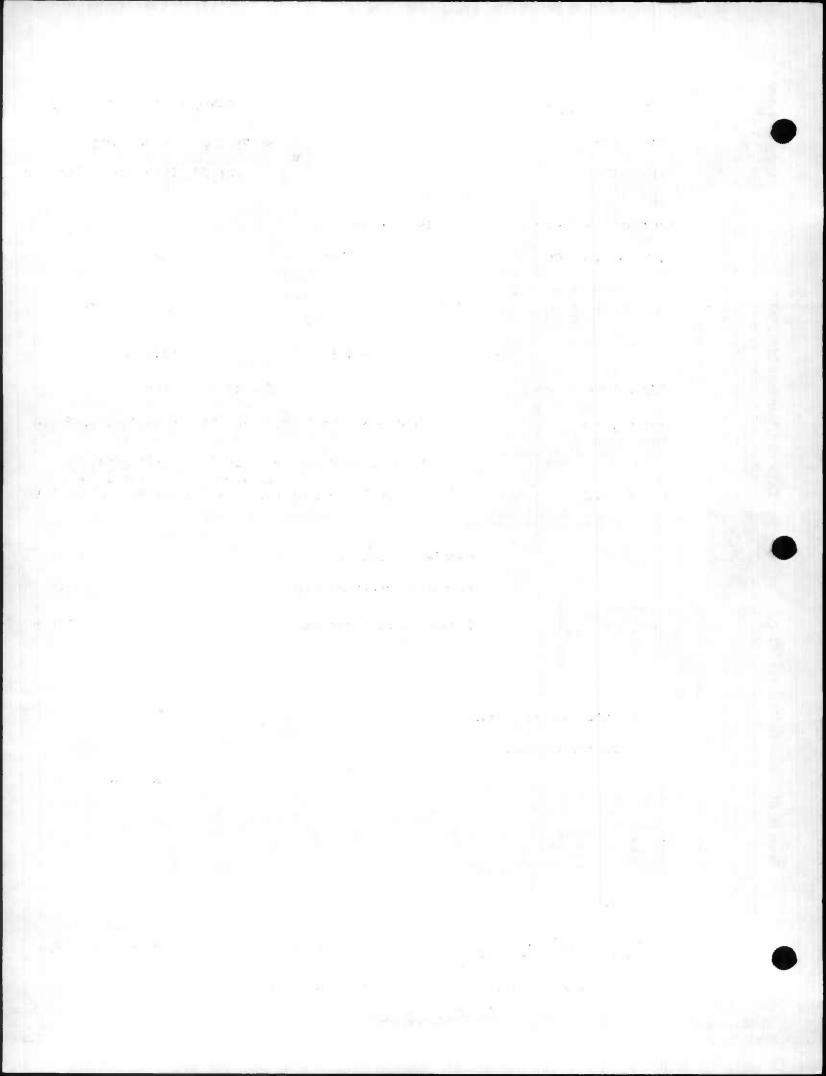
29b. Signature and title of cartifier

30. Neme end eddress of perso

Edward S. Mehlman



h who completed cause of deeth (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth 3. Time of Death **Physician** Month Owen Edgar Mills February 13, 1998 8:25A. /Medical 4a. Facility Neme (If not institution, give streat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Magnolia Gardens Nursing Home Lanham Prince George's 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

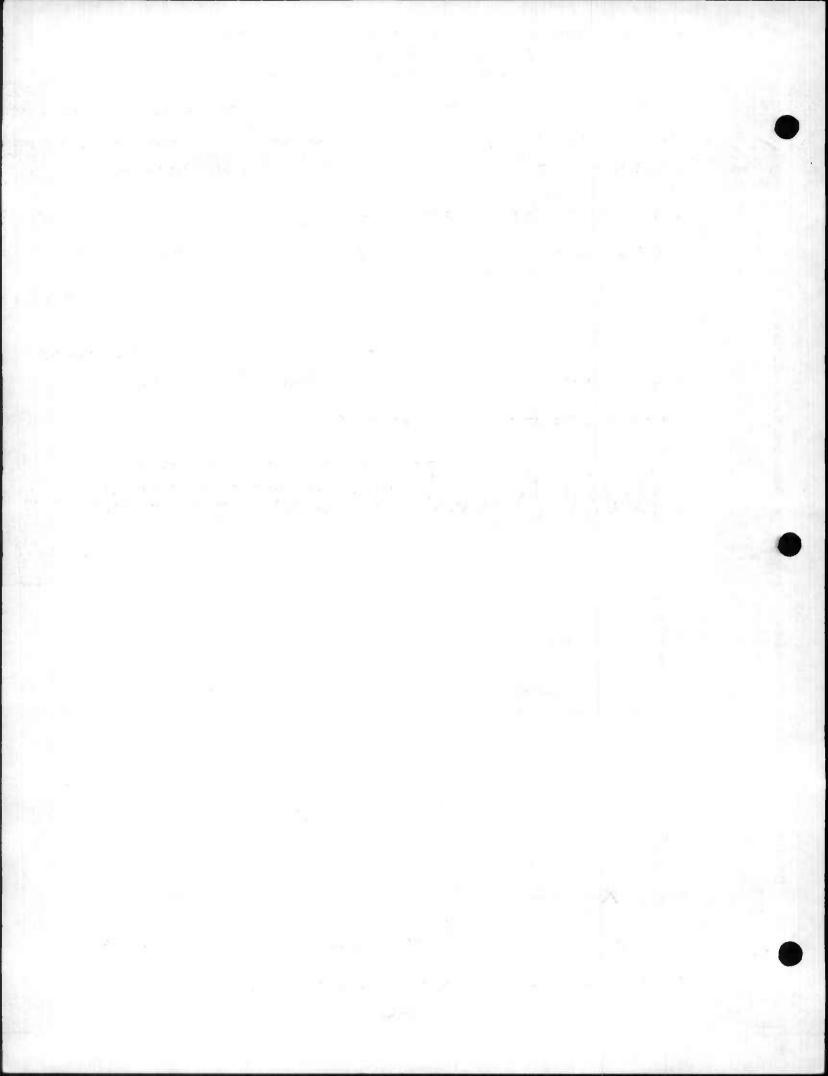
O1 Months Deys Hours Min. 8. Dete of Birth (Month, Day Year) 9. Birthplect Country)
April 15,1906 Iowa 9. Birthplece (State or Foreign **Funeral** 478-09-1217 XXM 2□ F 91 Yrs. Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show soical Examiner must be notified at Maryland Prince George's Berwyn Heights 1 Yes 2XNo Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8701 62nd Avenue 20740 United States death Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. Important: if them 27 is marked other than "natural" or inserting them of the marked other than "natural" or inserting the marked other than "natural". XXYas 2 No If Yes, Give Yaar or Dates: WWII 1 Never Married MM Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer Government Printing 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Edgar J. Mills Laura Bagby 2 19e. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mildred M. Mills (wife) 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) Hamburg Cemetery 2/19/1998 Hamburg, Iowa 21. Signal 22. Name end Address of Fecility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Parti. Enter the disease, of complications that raused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one cause on jach line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediata Ceuse (Final freumon 10 days disease or condition resulting in death) Examiner Due to (or es e consequenca ot): be axecuted buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Lest and Due to (or es e consequence of): Box 68760. nding physiclan Physician/Medical the Due to (or es e consequenca of): 98 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contribute to the cause of death? signed by t d be detect 1 Yes 2 No 3 Probably 4 Unknown 20/01 60 or cla ane Records, þ 24b. Ware eutopsy findings available prior to completion of causa of death? 24e. Wes an autopsy performed? Completed peen page 2 hes . 1 Yas 20 No certificate Division of Vital Attanding Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28c. Injury at Work? 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28b. Time of After 1 Watural 5 Pending To the Hospital or Attandir within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No Investigetion 2 Accident by the 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) and manner stated. Medical pletaly 29b. Signeture end title of cartifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 10 would, February 13, 1998 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Don Yablonowitz, M.D. 7404 Executive Place, #502 Seabrook, Maryland 20706 31. Data filad (Month, Dey, Year) Segistrary Signature State

DHMH 16 Rev 6/95

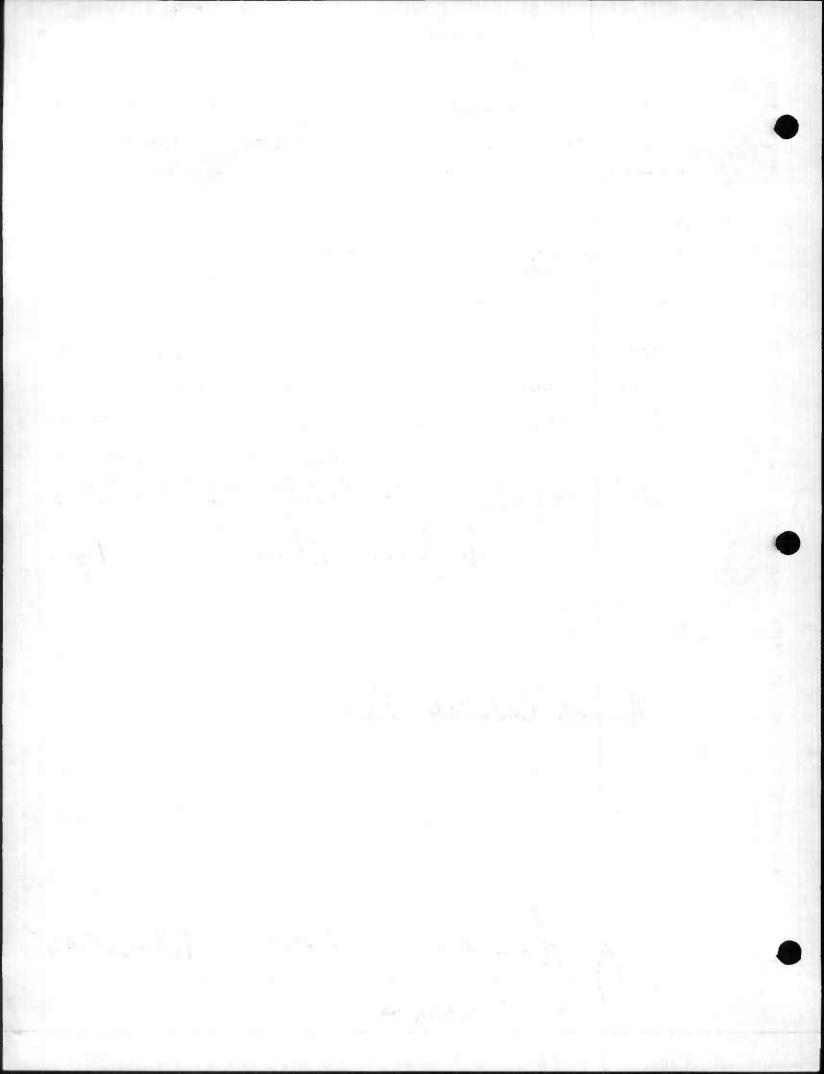
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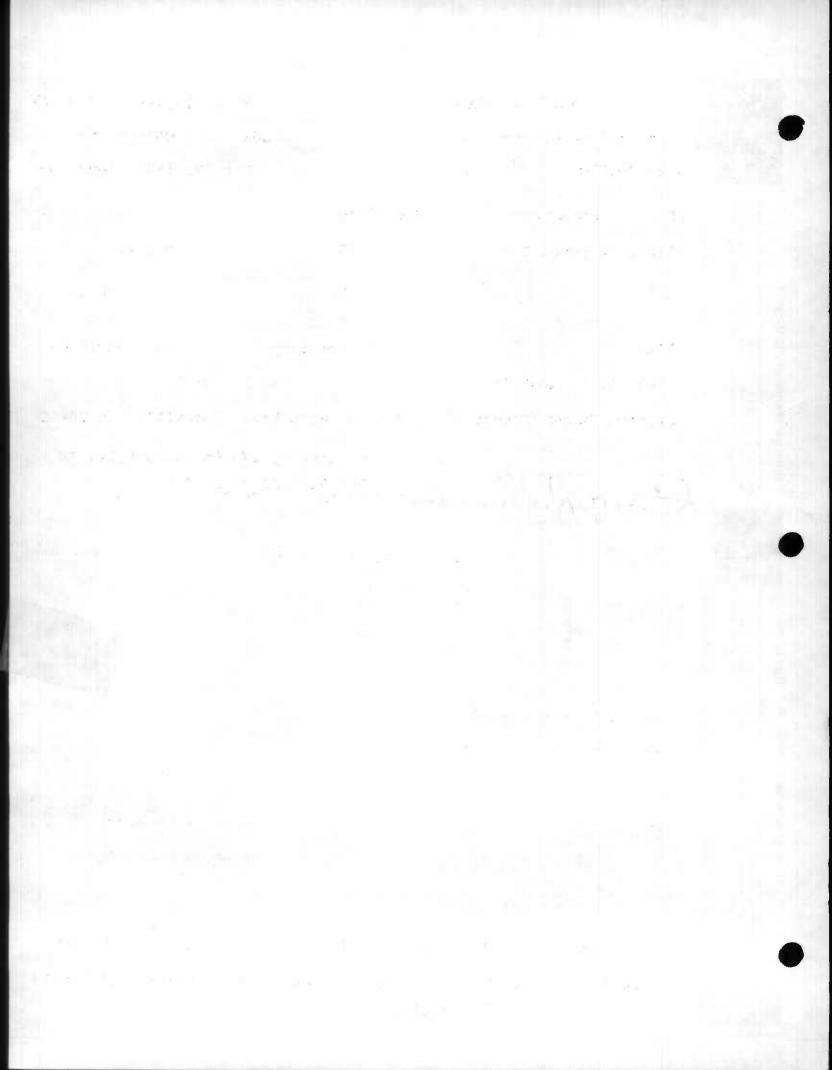
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	2 should and Men is marke aumatic		19a. Informant's Name/F	lalationship (7	Typa, Print)		19b. I	Mailing Addra	ss (Street	and Number or Ru	ral Routa Numbe	r, City or Town,	State, Zip	Coda)
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	requiras that tha death cer been signed by the attendin hould be datached for use	by Phy	Antoni	clerte	Andio	Ursal	h	Clisa	je		101	res 2□ No	3 □ Proi	pably 4 Unknow
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State of Maryland / Department of Health and Mental Hygiene 98 06846

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1,		1	30. Name and address	ss of person wh	o completed cau	use of deeth (Item	23e) (Type,	Print)						1	
					Blass				203	rgeto	wn	Rd, Be	thesda	, M	d #20814
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State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Daath 3. Time of Death Month Vaar **Physician** Elaine Iris Rubinoff Moos February 12, 1998 2:45 PM /Medical 4e. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15718 Mahogany Circle #302 Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) **Funeral** 1□M 2⊠F Yrs. Director 197-44-4284 45 May 23, 1952 Pennsylvania Usual Rasidance of Dacedant deeth with the Marylend 10a State 10h County 10c. City, Town or Location 10d. Insida City Limits tem 27 is marked other than "natural", or items 23e or 28a-f sho other treumatic event, the Modical Examiner must be notified at Maryland 1K Yas 2 No Director Montgomery Gaithersburg 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 15718 Mahogany Circle #302 20878 United States Funeral or Herns 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☒ No If Yas, Give Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, Whita, atc. Pages 1 end 2 should be filed within 72 hours efter 1 Navar Married 2 Married 21215-0020 1 Yas 2 No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usuai Occupation 16b. Kind of Businass/Industry (Giva kind of work done during most of working lifa. DO NOT usa ratired) Hygiene. Elemantary/Secondary (0-12) Collaga (1-4or 5+) Gardening/Real Estate Free Lance Writer Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Depertment of Health end Mental I important: If Item 27 is marked of any Injury or other treumatic eve Morris Rubinoff Not available 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 15718 Mahogany Circle #302, Gaithersburg, MD 20878 Roger Anthony Moos/Husband 20b. Place of Disposition (Nama of cematary, cramatory or other place) Feb. 14, 1998 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funaral Sarvica Licensaa

22. Name end Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part1. Entar the disaasa, or complications that caused the daeth. Do not antar the mode of dying, such as cerdiac or raspiratory arrast,

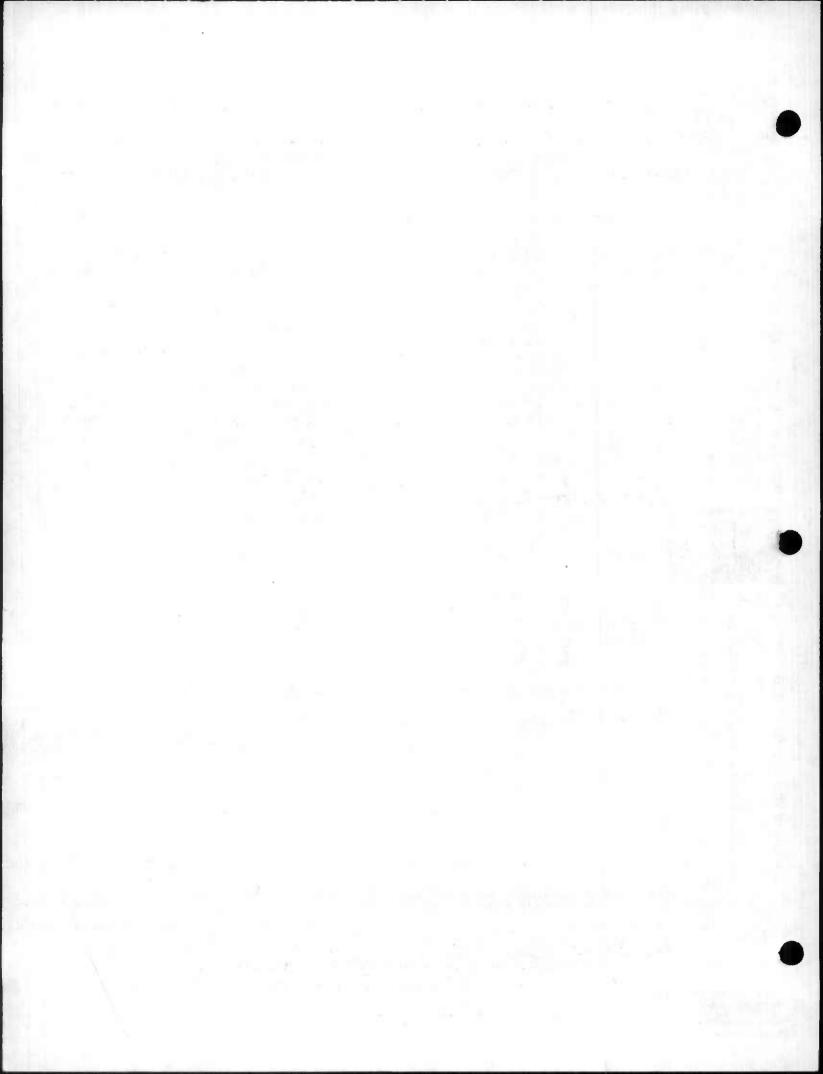
Approximata Onsat and Death **Physiclan** /Medical immediata Cause (Final disaasa or condition rasulting in daath) 3 years Examiner Dua to (or as a consequance of) The law requires that the death certificete be executed Sequantially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in deeth) Last Bud Dua fo (or as a consequance of): Box 68760, the ettending physiclan Physician/Medical the Dua to (or as e consequance of): Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Melnutrition secondary to nause + vomiting ģ Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of causa of daath? certificete 1 ☐ Yas 2 No 1 Yas 2 240 or Attending Physician: Be 25. Was cesa rafarred to medical axaminar? 26. Piace of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospital: 1 ☐ Inpatienf 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yas 2 No this 27. Mannar of Daath 28a. Date of fnjury (Month, Day Year) Certification: 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After ie Hospital or Attenums in 24 hours effer deeth. the Funeral Director: Affe 5 Panding invastigation 1 Staturei 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarminad 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Medical 29a. Cartifian 1⊠ Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and piace, and dua to tha ceuse(s) and mannar as stated.

2□ Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and piace, and dua to tha causa(s) and mannar statad. (Check only one) To the within 2 29b. Signature and tale of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) D35996 30. Nama and addrass of parson who complated ceusa of death (Itam 23a) (Type, Print) Linda M. Burrell, M.D. PARK MEDICAL DR#210 SILVER SPRING, MD 2101 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

DHMH 16 Rev 6/95

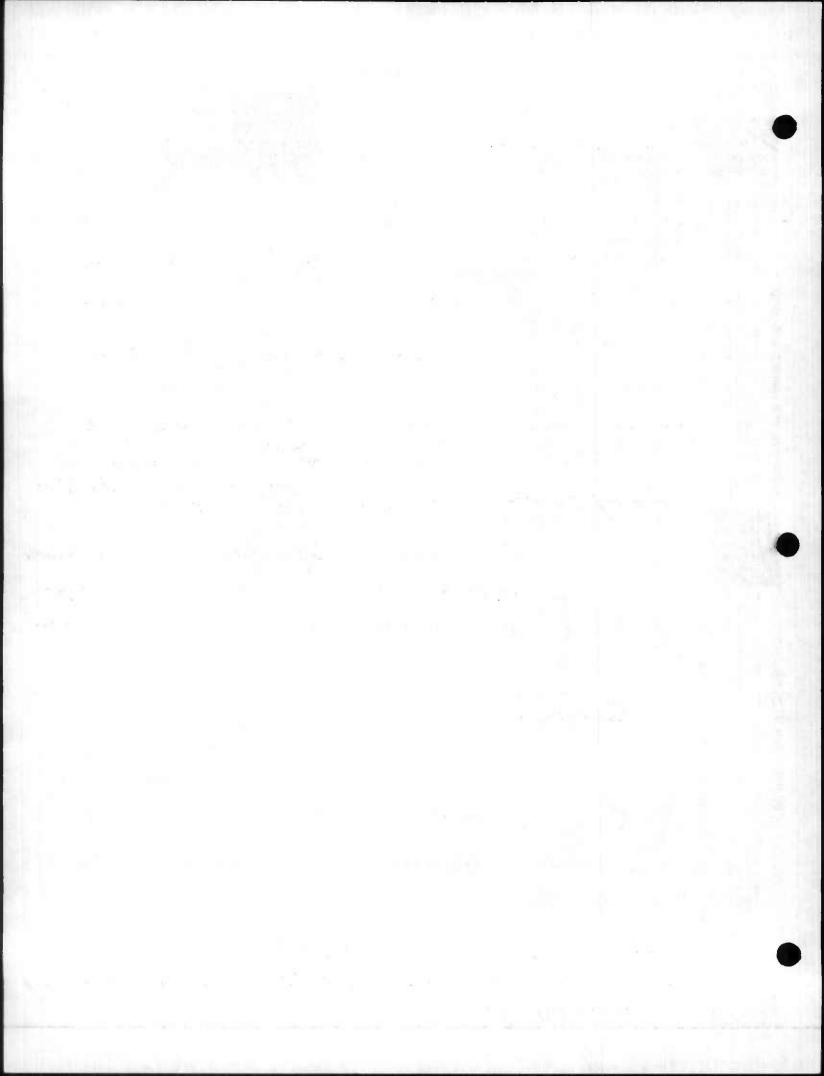
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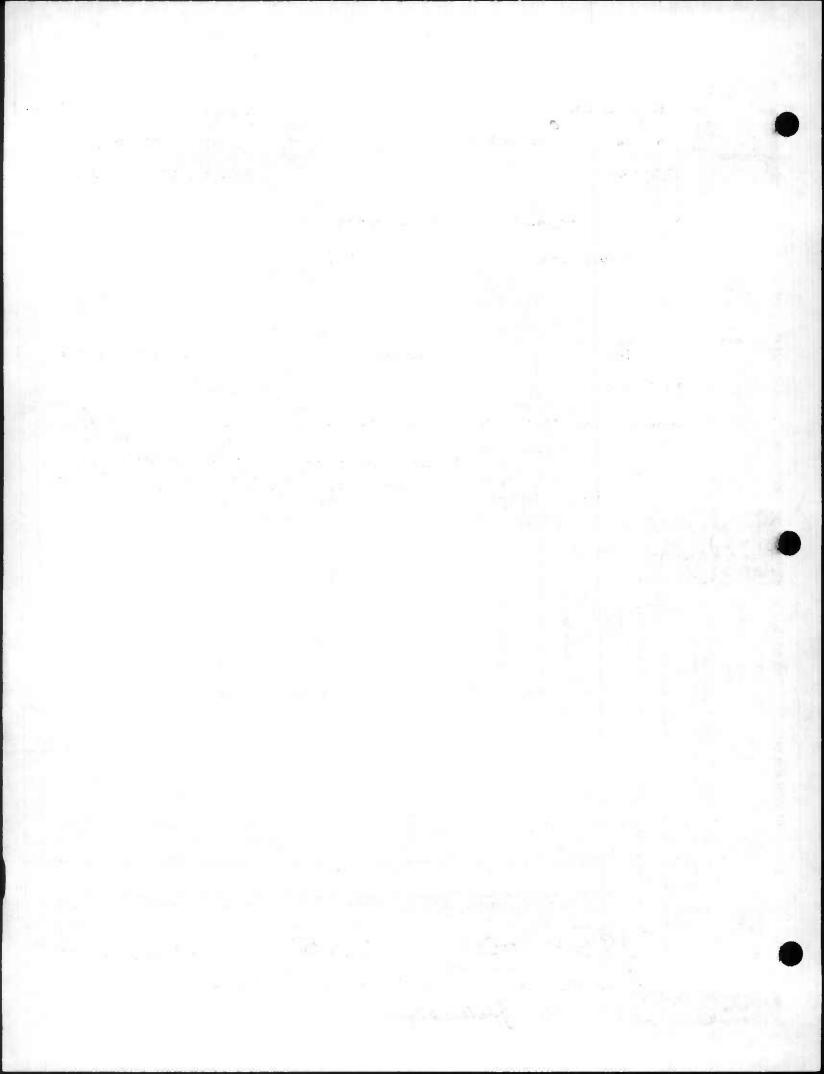
State of Maryland / Department of Health and Mental Hygiene Q

						Cer	tificate o	f Death		Reg.	No.	U	004	8
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	Physic /Medi]	reeman Ern	est Mo	organ,	Jr.			bruary	11, 1		6:06	PM
}	Exami		4a. Fecility Neme (If not institution,	give street end number	r)			4b. City, To	wn, or Locati	on of Deeth	4c. County	of Deeth		
			Montgomery Gen	eral Hospit	tal			01	ney		Mont	gomer	У	
	Funeral		The state of the s	5. Sex 7. A 1 ☑ M 2 □ F	ige (In yrs. le		If Under 1 Yes Months Day		24 Hrs. 8. Min.	Dete of Birth (Month, Dey, Ye	er)	9. Birthple	ece (Stete o	or Foreign
	Director		356-05-4170	TOLM ZUF	84	Yrs.	0000000	145,000	Ju	ine 16,	1913	Illi		
3	, a		Usuel Residence of Decedent 10a. Stete 10b. County		10c City	Town or Loc	nation					40	d toolse O	20 1 120-
	eho eho	5										10	d. Inside Ci 1 ☐ Yes	
	Se-I	Director	Maryland Montgo	mery	511	ver S								2 22 140
1	0 0	吉	10e. Street end Number				10f. Zip Code			10g.	Citizen of W	/het Count	ry?	
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	He man	Funeral	11. Meritel Stetus	12. Wes Decedent Armed Forces	?	. 13. W	as Decedent of Yes, specify Co	f Hispanic Ori uban, Mexicen	igin? (Specify n, Puerto Rice	Yes or No- in, etc.)		- Americe k, White, e		
20	0 0	by F	1 ☐ Never Merried 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	T 77 T - T -	T 1	☐ Yes 2🖺 N	io Specify:			Specify:	T.71		
Maryland 21215-0020	/z hours ener deem with the Maryland natural, or frems 23s or 28s-f show pical Example must be notified at			Yeer or Detes:	: WW II						140 . 4	Whi		
5	"ned"	Completed	15. Decedent's (Specify only highest			(Give k	ent's Usuei Occ and of work dor O NOT use ret	cupetion ne during mosi imal)	t of working	166	. Kind of Bu	siness/indu	istry	
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7	Ther	2	19a. Informent's Name/Relationship			10h Mailine	Address (Stre		-	oute Number, Ci		State 7in f	Codel	
N S	Trans.		Richard K. Morga							alls, V				
e :	is i and z if Haelth a Item 27 le other trai		20e. Method of Disposition	111/ 5011	20b. Ple	ce of Dispos	ition (Neme of	oau, G	reat r	ete 20c	Location - 0			
Baltimore,	int of in		1 ☐ Burial 2 ☐ Cremation 3		e cen	metery, crem	ition (Neme of etory or other p	lece) Feb.	. 13,	1998				
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Ba	permit. Tegas I and 2 should be med which 22 hours ener deem with the Marylan Department of Heelth and Mential Hygiene. Important: If them 27 is marked other than "natural", or frems 23s or 28s-f show any injury or other traumatic event, the Medical Examines must be notified at Once.		Rout to	end	M00198	Rg B	West ockvill	Pumph Montg	rey Fu omery	neral H Avenue 20850-	ome/Ro	ockvi.	11e,	Inc.
			23e. Pert1. Enter the disease, or co shock, or heart failure. List or	emplications that cause	ed the deeth.	Do not ente	r the mode of d	lying, such es	cerdiec or re	spiratory errest,	200	1 1	Approximete	0
	hysician												Onset end (Deeth
	/Medical Examiner		immediate Ceuse (Finel disease or condition	Acu	To m	Lyonar	deal -	Tripa	reten	J		5	5mn	rutes
	.xammer		resulting in death)		Due to (or a	as e consequ	deal -	0						
7	2 %	ine		Hyp	renter	sear	フ						27 4	ears
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Вох	attendi for use	lan		0										
	ad by the attendidate use	Physician/I	Pert II. Other significant conditions	contributing to death I	but not result	ing In the un	derlying ceuse	given in Pert I.		23b. Did tobac	co use con	tribute to	the cause (of death?
P.O.	d by		Stron	Ke_						1 🗆 Yes	2□ No	3 Probe	ibly 4 🕾	Unknown
Ś	been signed to	by						-						
oro	Pen s	Completed								24e. Wes en eu performed	itopsy ?	avei	e eutopsy f leble prior t	to
0	as b	ple										of de	pletion of c eeth?	euse
H 2	ate h	S								1 ☐ Yes	2 NO	1 🗆	Yes 25	No
ita	certificate has rector, page 2	Be (25. Wes cese referred to medical exeminer?					26. Plece	of Deeth (C	neck only one)				
1	dire	To T	1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpati	ient 2 E	/ R/Outpatient	3□ DOA	Other: 4 Nu	irsing Home	5 Residence	6 □Othe	r (Specify)		
Division of Vital Records,	tar th neral		27. Menner of Deeth 1 ☑Naturel 5 ☐ Pending	28e. Dete of Injui	ury 2	8b. Time of Injury	28c. In	jury et /ork?	28d.	Describe how in	njury occurre	ed		
0	A: A	atic	2 ☐ Accident investigat	ion		,,		☐ Yes 2☐	No					
N N	er de recto	t t	3 Suicide 6 Could no 4 Homicide determine	ad 286. Piece of in	njury - At hom	e, farm, stre	et, factory, offic	÷0		Location (Street City or Town, St		er or Rurel	Route Num	ber,
בֿ בֿ	al Di	Certification:		January, 0	(Speedig)					9				
To the Hospital	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 1 ☐ Certifying 2 ☐ Medical Ex	Physician: To the best aminer: On the basis of end manner st	of exeminetio	edge, deeth en end/or inve	occurred et the estigetion, in my	time, dete end opinion, deel	d plece, end of th occurred e	due to the ceuse t the time, dete	e(s) end mer end place, a	nner es ste and due to t	ted. the ceuse(s	;)
4	Nithir To th	5	29b. Signeture end title of certifier				29c. Lice	nse number		29d.	Dete signed	(Month, D	ey, Year)	
5	14		Worker	n D			1)	3/91	9	F	Passe		1 199	V
15),,		30. Name and address of person wh	o completed cause of	death (Item 3	3a) (Type D	Print)	JUELL	1	17	vrua	J.	(9
			30. Name and address of person when the street of the stre	Res was	3305	Nortu	leesure	Worker	Soule	rack Si	Wers	ngua	Mar	ylen A
1	Sta	te	31. Dete filed (Month, Dey, Yeer)	32. Pegist	rer's Signetui	10				700	-, -		201	206
	Registr			198 grain	treds Signetur	n-Manda	2							



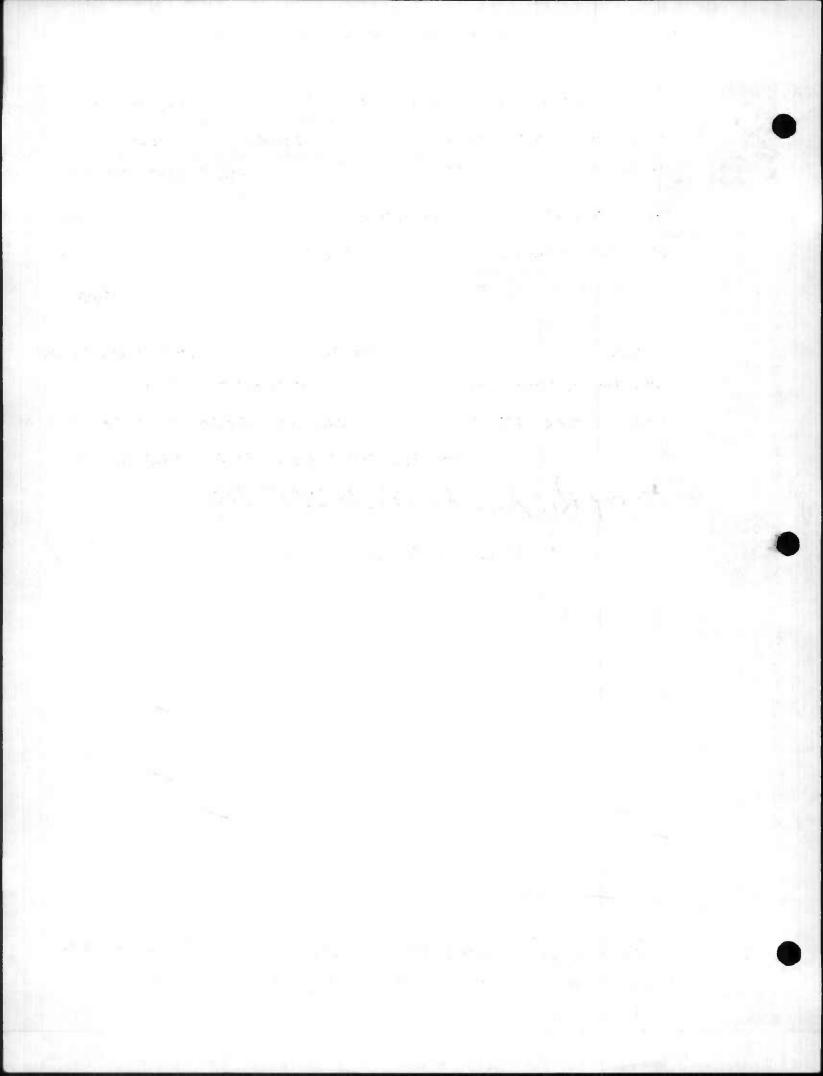
State of Maryland / Department of Health and Mental Hygiene 98 16849

					Cei	rtificate of	Death		Reg. No.	00045
Dharal	-:	1. Decedent's Name (First, Middle,	Last)					2. Dete of Dee	eth Dey	3. Time of Death
Physi /Med		Naomi C. Murp	hy					FEBRUARY	15	1998 2:15 p.n
Exam		4a. Fecility Neme (If not institution, g	give street end nu	ım <i>ber)</i>	X		4b. City, Town, or	Location of Death	4c. County	of Deeth
		Brooke Grove	Nursing	Home			Olney		Mont	gomery
Funera Directo	_	577-07-0715	. Sex 1 □ M 2 ☑ F	7. Age (In yr. 87	s. last birthday) Yrs.	If Under 1 Yea Months Deys			y, Year) 9, 1910	9. Birthpiece (State or Foreig Country) Delaware
pur *	- 0	Usuel Residence of Decedent 10a. State 10b. County		10c (City, Town or Lo	cation				40d Incide City Limits
sho	2			100.0						10d. Inside City Limit:
he N	Director	MD Mont	gomery		Silver	Spring				
ath with		17423 Astoria L	ane			10f. Zip Code 2090	05		10g. Citizen of V U.S.	
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, its Medical Exemper mail be notified at once.	by Funeral	11. Marital Stetus 1 □ Never Merried 2 □ Married 3 □ □ Widowed 4 □ Divorced	Armed Fo	22 No		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispenic Origin? (sban, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)	Specify	e - American Indian, ck, White, etc. White
5-0 72 hc	Completed	15. Decedent's (Specify only highest of	Education		16e. Deced	dent's Usual Occu	upetion	rking	16b. Kind of Bu	usiness/Industry
21 Fan :	npie	Elementary/Secondary (0-12)	College (life. L	DO NOT use retir	e during most of wo ed)	orking		
No le la la la la la la la la la la la la la	Son	10			Book	keeper			Nationa	l Geographic
Toth de file	e e	17. Fether's Neme (First, Middle, La	st)				18. Mother's Na	me (First, Middle,	Maiden Sumem	ne)
V a	0	Wallace Cook	*				Lilli	e Shipe		
She end		19e. informent's Neme/Retationship	(Type, Print)				et end Number or A			
end ealth n 27			(daughte				a Lane, S	ilver Sp	ring, M	D 20905
of H of H if iter		20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3	□Removal from		Plece of Dispo cametery, cren	sition (Neme of netory or other pl	ace)	Dete	20c. Location -	City or Town, Stete
Pag ment ant:		4 Donetion 5 Other (Spec			etropol:	itan Cre	matory	2/16/98	Alexandi	cia, Virginia
Ball permit. Depend Import		21. Signature of Funerel Servica Llc	ansee	le	Но	Me, Inc	ress of Fecility 500 Un	Francis C iversity 20901	J. Colli Blvd.	ins Funeral West
		23a. Pert1. Enter the disease, or co shock, or heart failure. List on	mpic tions thet	eused the de					rest,	Approximete
Physician /Medical		Immediate Ceuse (Final disease or condition	Vo	`umon						Intervel Between Onset end Deeth
Examiner		resulting in deeth)	е		(or es e conseq	uence of):				1 3 weers
nsit	Examiner		b			1				
e exect ian end unal-tra		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury		Due to	(or es e conseq	uenca of):				
BOX 68/6U, asth certificate be executed ettending physician and for use as the burial-transit	Medical	that initiated events resulting in deeth) Lest	С	Due to	(or es e conseq	uence of):				
BOX ath cert strending			d							
the dear	Sic	Pert fl. Other algnificant conditions	contributing to de	eath but not re	sulting in the ur	nderlying ceuse g	iven In Pert I.	23b. Did to	obacco use co	ntribute to the cause of death
IS, F.O. BOD	by Physician/	EMPHYSEMA						100	res 2□ No	3 Probably 4 Unknow
aw requir	Completed t			-				24e. Wes e	en eutopsy med?	24b. Were autopsy findings evellable prior to completion of cause of deeth?
The Is	Cor							1 🗆 Y	es 200No	1 ☐ Yes 2 No
ysician: Thysicians s certificate	Be	25. Wes case referred to medical examiner?						eth (Check only o	ne)	
OI VITA Physician: this certific	10	1 Yes 2 No			☐ ER/Outpetlen	T 3LI DOA		Home 5 Resid	ence 6 Oth	er (Specify)
Attending P or deeth. octor: After the by the funeral	ation:	27. Menner of Deeth 1 Anatural 5 Pending 2 Accident Investigati	on	of Injury th, Dey Year)	28b. Time of Injury	W	uryet ork?]Yes 2 ☐ No	28d. Describe h	ow injury occurr	red
DIVISIO Ital or Attendi Its after deeth. al Director: A led in by the fi	Certification:	3 ☐ Sulcide 6 ☐ Could not determine	289. PIBCB	of Injury - At I ng, etc. (Spec	home, ferm, stre ify)	eet, fectory, office		28f. Location (5 City or Tow		er or Rurel Route Number,
To the Hospital or A within 24 hours after To the Funeral Direc	edical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exe	iminer: On the ba	best of my kn asis of exemin ner steted.	owiedge, deeth etion end/or Inv	occurred et the trestigetion, in my	ime, dete end plece opinion, deeth occi	e, end due to the durred et the time, d	eause(s) end me dete end placa, o	enner es steted. end due to the cause(s)
To the Young	Me	29b. Signeture and title of contifier				29c. Licen	se number	- 2	29d. Date signed	d (Month, Dey, Year)
4		JEHOW	e. M	D		D33	700		Februar	15.1998
		30. Neme end eddress of person who	o completed caus			900	0		- 31 9121	15,1998
		IED-E. HOWE	754	2 0	TVERLOOK	C BRIV	F, KOC	NSBORC) M	D
St	ate	31. Dete filed (Month, Dey, Year)	32. 7	egistrer's Sign	neture					



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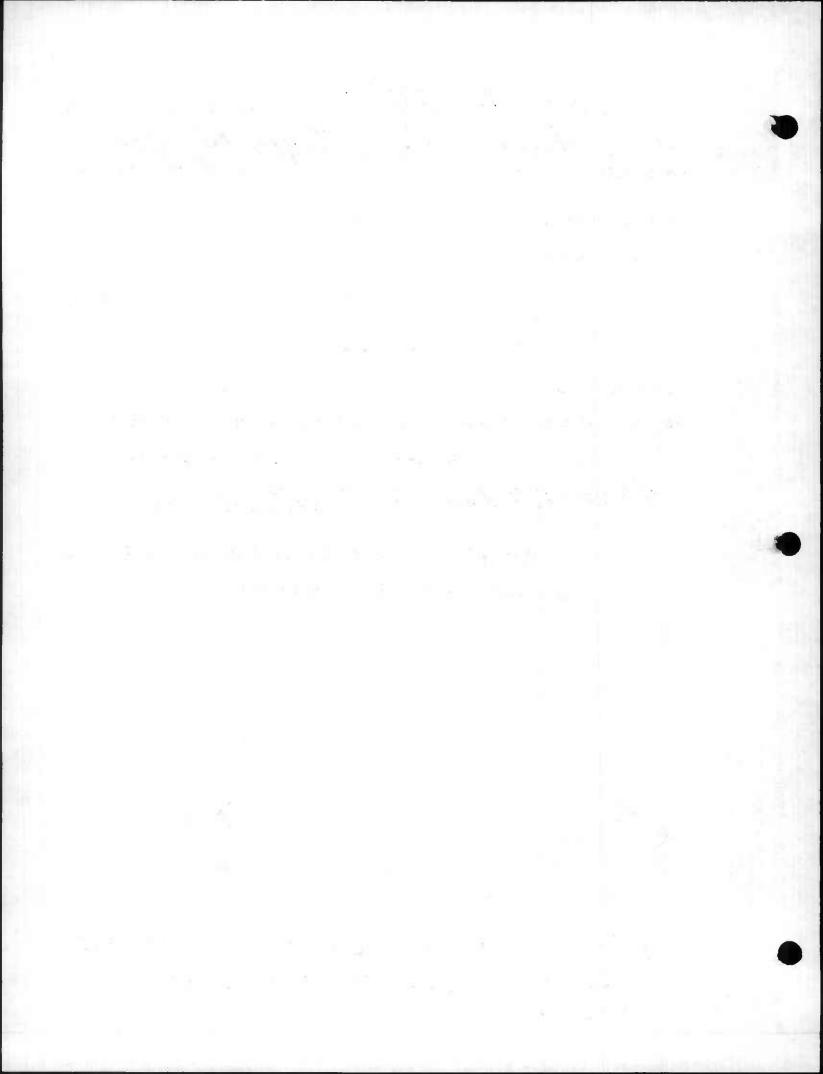
		1. Decedent's Neme	/First Middle La	st)		Ce	rtificat	e of	Death	2. Dete of Deat	eg. No.		2 Time	of Death
Physicia			WILLIAM	_	1	MYERS,	JR			Month Feb	Dey 1	Yeer Q Q Q		01 Pm
/Medica Examine	- 11	4a. Fecility Neme (If	not institution, giv	a street and number					4b. City, Town, or		4c. County		10:0)I PIII
EXCITITION	•	5453 W	ooden H	Hawk Cir	ccle				Columbi	a	How	ard		
Funeral Director		5. Social Security Nu 219-38-7		ex 7. □ M 2□ F	Age (In yrs 58	. last birthdey) Yrs.	Months Months	1 Yeer Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, Jul 8,	Year) 1939	9. Birthpl Count Mar	ece (Stete try) Ylar	e o <i>r Foreign</i>
p .		Usuel Residence of I			40-0									
a or 28a-f show	2	10a. Stete Md	10b. County Howard	4	10c. C	ity, Town or Lo						10		City Limits
Start Start	ecto	10e. Street end Num		^		COTUI	_	Codo			0		25	92 2 140
23a or Nat be	Funeral Director			lawk Ci	ccle		10f. Zip	210	44	1,	0g. Citizen of V		ry r	
200	P	11. Marital Status 1 Never Marrier 3 Widowed 4		12. Wes Decede Armed Force 1 Yes 2 if Yes, Give Yeer or Dete	s? ☑ No				dispenic Origin? (S en, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Bled	a - America ck, White, e	etc.	
than 'natural', the Medical Ex	Completed		5. Decedent's Ed y only highest gradery (0-12)		or 5+)		dant's Usua kind of wo DO NOT us		oation during most of wor d)		16b. Kind of Bu			Со
ent,	Ö	17. Fathar's Neme (F	irst, Middle, Last)							ne (First, Middle, M				
Menta sriced c	To Be	Willi	am R. M	yers, S	Sr.				Mildr	ed B. W	ilson			
and A		19e. informant's Nen	ne/Raletionship (7	Type, Print)		19b. Mailir	ng Addrass	s (Straal	and Number or Ru	rel Route Number	City or Town,	State, Zip	Code)	
then 27 h other tra		Minnie	P. Myer	s (Wife	e)	545	3 Wo	ode	n Hawk	Circle,	Colu	mbia	, MD	21044
				Removel from Sta	te	Ptece of Dispo cemetery, crer	metory or o	other ple	ce) Cem. 2		Higl:			
Department of Important: If any Injury or once.		21 Signeture of Fund		·	0	22 S	2. Name en	Addre	ess of Fecility FUNERAL					
	7	23e. Part1. Enter the shock, or haart	Sex.	11/10	nd	U R	OCKV	ILL	E, MD	20850			Approximintarvel B	
xa xa xa xa xa xa xa xa xa xa xa xa xa x	Examiner	immediate Cause (Fi disease or condition resulting in deeth)		. Mwn	Dua to (or es e consec	quence of):	Ca	ncer				lyen	is
unal-tra	Exar	Sequentially list conditions, laeding to immediate. Enter Underly Ceuse (Disease or In that initiated events	litions, nediata ying		Due to (or es e consec	quenca of):							
inding physician and use as the bunal-transit	Physician/Medical	that initieted events resulting in death) Le	st	d	Due to (or es a conseq	uenca of):							
attandin for use	Clar	Dod it Other similia	and and distance of		h		-1-1							
		Pert it. Other eignific	ant conditione co	ontributing to death	but not ras	sulting to the u	nderfying c	ausa gh	/en in Parti.	23b. Did to	becco use cor			Unknown
2 shoul	Completed by									24a. Wes en	n eutopsy ned?	eva	ra autops illable prio npletion o laath?	sy findings or to of cause
ate he	E O									1 □ Ye	s 20 No	1 🗆	Yes 2	□No
	Be	25. Was case referre exeminer?	d to medicai						26. Plece of Dee	eth (Check only on	9)			
	0	1 ☐ Yes 2 ☑ N	0	Hospitel: 1 Inpe	tient 2	ER/Outpetier	nt 3□ DC	DA Oth	ner: 4 🗆 Nursing H	ome 5 Reside	nca 6 □Oth	er (Specify)	
After fune	Certification:	27. Manner of Deeth 1. Naturel 2 Accident 3 Suicide	5 Pending investigation		Day Year)	28b. Tima of Injury	М		ry et rk? I Yes 2 □ No	28d. Dascribe ho				
within 24 hours after death. To the Funeral Director: A completaly filled in by the fi		4 Homicide	determined	286. Pleca of	injury - At h etc. <i>(Speci</i>	nome, farm, str	reet, fectory	y, offica		28f. Location (St. City or Town		er or Hurel	Houre No	urn <i>ber</i> ,
within 24 hours after To the Funeral Dir completaly filled in	edical	29a. Cartifiar \$ (Check only one)	☐ Cectifying Phy ☐ Medical Exam	veiclen: To the bes liner: On the basis end menner	of axamine	owladga, daath etion end/or inv	n occurred vastigation	et the tir , in my c	ma, data and place ppinion, daath occu	, and dua to tha ca rred et the time, de	use(s) and me ete end pleca, o	nnar es ste end dua to	ted. the cause	e(s)
To the Com	Σ	29b. Signeture end til	le of certifier	,) , ,	,				se number	29	d. Dete signe	d (Month, E	ey, Yeer)
2	-	30. Nama and eddres	s of person who	Sove fre la	daath (Ita	m 23a) (Type	Print))38	rsoq hs leluu	F	ehunc	-,18	1992	3
		Nichelus		4405 110	165 Li	Itle PA	Иниен	+P	he Colum	chin une	2104	4		
State	е	31. Dete filad (Month,		32. Begin	Star's Sign	eture	00_							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death JEAN MARIE MOUGHAN 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** ean 9:40 AM FEB /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Coath Examiner RUQ NS en a 5. Sociel Security Number If Under 1 9. Birthplace (State or Foreign Country)
Pennsylvania 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Days 1 ☐ M 2 🗓 F 209-22-0138 68 Yrs. 1929 Director Usual Residence of Deceden with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Items 23a or 28a-f shov irver must be notified at 1 ☐ Yes XXNo Director Charles Maryland Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2754 Chevenne Court 20616 USA Completed by Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yas, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner. Peges 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 9 1 Yes 2X No Specify: White 31☑ Widowed 4 ☐ Divorced 'natural', 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry (Specify only highest grede completed) Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than any injury or other traumetic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) Be Robert F. Morgan Grace Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Numbar, City or Town, Stete, Zip Coda) Mary Kay Benavente - Daughter 2754 Sheyenne Ct., Bryans Road, MD 20616 20e. Mathod of Disposition 20b. Placa of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland Veterans' Cem. 2-26-98 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Fecility Shannon W. Ramirez Huntt Funeral Home, Inc. M00798 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirefory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** a. AMYOTROPHIC LATERAL SCLERGIS

Due to (or as e consequenca of): /Medical Immediate Cause (Final diseasa or condition rasulting in death) Examiner Examiner CANCER The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Disaase or Injury that initioted events resulting in death) Last Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Due to (or es e consequence of), Part II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Unknown by should be Be Completed 24b. Ware autopsy findings evallable prior to completion of cause of daath? 24a. Was en eutopsy performed? peen: page 2 After this certificate hes 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was case raferred to medical axaminer? 26. Place of Daath (Check only ona) 1 Yas 26 No Othar: 4□ Nursing Home 5 Residence 6 □ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA spital or Attending Physhours after death.
neral Director: After this y filled in by the funeral di 27. Manner of Daath Date of injury (Month, Dev Year) Medical Certification: 28b. Time of 28d. Describe how Injury occurred 28c. injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 \ Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physicien: To the best of my knowledga, death occurred et the time, data and place, and due to the causa(s) and manner as stated.

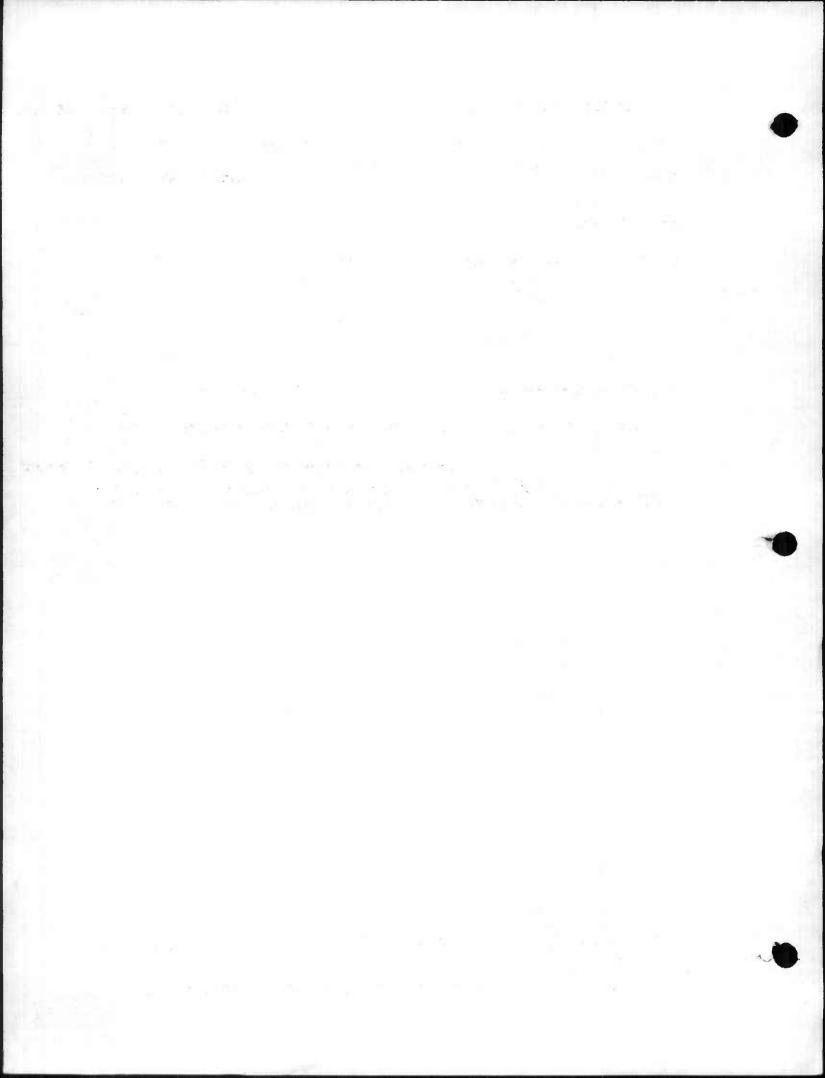
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State FEB 2 3 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O.

					C	ertificate of		F	leg. No.	j U	685	2
	Physici	an	1. Decedent's Name (First, Middle, L		D			2. Date of Dea Month	Dey	Year	3. Time of D	
1	/Medi	al	THOMAS RICHARD 4e. Facility Name (If not institution, g				4b. City, Town, or Le	01	12	98	1:49	A.M.
7	Examir	er	National Insti				•		4c. County			
ŀ	Euporal				altn ge (In yrs. last birthde	y) If Under 1 Yeer		8. Date of Birth (Month, Day		gome 1		Foreign
	Funeral Director		217-46-8625 Usual Residence of Decedent	10XM 2□ F	5.2 Yrs.	Months Deys	Hours Min.	(Month, Day April 8,		Maryl	eca (State or I etry) and	
	anyland ahow		10s. Sfete 10b. County		10c. City, Town or	Location				1	0d. Inside City	
	Ne M	ecto	Maryland Charle	S	Hughe	sville					1 ☐ Yes 2	2 NO
	vith th	Dir	10e. Streef and Number			10f. Zip Code		1	log. Citizen of		itry?	
	e 23	erai	15198 Hughesvill 11. Marital Status	e Manor Dr		2063		acity Vac or No.	U.S.A	e - Americ	on Indian	
020	72 hours after death with the Meryland natural', or items 23a or 28a4 show diest Examinet must be notified at	by Funeral Director	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces'	No	If Yes, specify Cub	Hispanic Origin? (Speen, Mexican, Puerto Specify:	Rican, etc.)	Specif	ck, White,		
Maryland 21215-0020		Completed	15. Decedent's I (Specify only highest g Elementery/Secondary (0-12)	Education rade completed) College (1-4or	5+)		pation during most of work ed)	ing	16b. Kind of B			Ť
7	her th	Co	12th 17. Father's Name (First, Middle, Las	MAI .	Con	icrete Mas	18. Mother's Nam	o (Cinet & Aidelle	Constr		on	
ano	d be f	Be o	Carroll Richard							пеј		
7	should Me mark matic	To	19a. informant's Name/Relationship		19b. Me	iling Address (Street	t and Number or Rur	deline		State Zin	Code)	
	ges 1 end 2 should be filed within to filed within to file health and Mental Hygiene. If item 27 is marked other than or other traumatic event, I a Me		Thomas Richard M				52 Mecha					
Je,	of Hee frem othe		20a. Method of Disposition		20b. Place of Dis	position (Neme of remetory or other ple		Date	20c. Location			
E	Page net c int: H iry or		1 ☐ Burial 2 ☐ Cremetion 3 4 ☐ Donetlon 5 ☐ Other (Spec	□Removai from State :ify)			lary Cemeter	1/15/98	3 Levino	rton Pa	rk Mars	vland
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, its manes.		21. Signaffare of Funeral Service Lion	agues La co	1-	22. Neme and Addr Mattingle	ess of Facility y-Gardine	r Funer	al Home	, P.	Α.	LIGILIA
			23a. Part1. Enter the diseese, or con shock, or heart failure. List onl	mplicetions thet cause	d the death. Do not e	P.O. Box enter the mode of dyl	270, Leor Ing, such es cardiec	ardtown or respiretory ari	, Maryl rest,	and	Approximate	
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	cuted	ami	Sequentially list conditions,	b	Due to (or as a cons	1						
90,	s exe	E	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury							i		
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P.0.		Physician/M	Part II. Other significant conditions				ven in Part I.	236. Did to	obacco use co ∕es 2□-No	3 □ Prot		I death? Inknown
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E .	The late has page	Con						1 🗆 Y	es 2 No	10	Yes 20-14	10
of Vital	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Harris II		1 =	26. Place of Deat	h (Check only or	10)			
of	this aldi	T-	1 ☐ Yes 2 ☐ No	Hospital: 1 Unpati		ent 3L DOA		me 5 Resid			v)	
uo	After After funer	lon	27. Manner of Death 1 Natural 5 Pending	28a. Date of fnje (Month, De	by Year) 28b. Time Injury	Wo	ry et ork?]Yes 2 □ No	28d. Describe h	ow injury occur	rred		
Division	Attend r deati ctor: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	be go Diese of to	jury - At home, ferm,		1103 2 1140	28f. Location (S	treet and Numi	ber or Rura	I Route Numbe	er,
Š	s afte	Sert	4 Homicide		ic. (Specify)			City or Tow	n, Stete)			
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completaly filled in by the funeral director, page	Medical (29e. Certifier (Check only one)	hysician: To the best miner: On the basis of and menner st	f examinetion and/or	ath occurred at the ti investigation, in my	me, date and place, opinion, death occur	and due to the dred et the time, o	ause(s) and m lete end placa,	anner as st and due to	ated. the cause(s)	
	To th Withir To th comp	M	29b. Signature end title of certifier	/	1CU ph	75 c. 29c. Licen	se number		29d. Date signe	ed (Month,	Day, Year)	
	r		1//01/	11	,	0101	05076	3	1/1	1/9	8	
~	1		30. Neme and address of person who	completed cause of	death (Item 23a) (Typ	e, Print)	00010		1	1		
rlz	I		JOHN F. MCDYER		ROCKVILLI	E PIKE, H	BETHESDA,	MARYLAN	D 2089	2		
	Sta Registr		31. Date filed (Month, Dey, Year)	998 32. Regist	Pareles Raro	lall						

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** FEBRUARY15 1998 10:20AM Bobby Everett Morgan /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** MEMORIAL HOSPITAL @ EASTON EASTON TALBOT If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Yeer) **Funeral** Deys Hours 1X M 2□ F 219-56-0182 Yrs. Director Apr. 24, 1950 Maryland Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at 1 Ves 2 No Director Maryland Queen Anne Grasonville 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 6 "natural", or Items 23a P.O. Box 241 Funeral 21638 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Rlack þ 3 Widowed 4 Divorcad Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7; th and Mental Hygiena. 7 is marked other than "na Elementary/Secondery (0-12) College (1-4or 5+) 8th Seafood Industry Laborer permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygis
Important: if item 27 is marked
any injury or other 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) 10 Thomas Morgan Lucy Unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Foster Adelaide Sheppard, daughter Fisher Manor, Apt. 2A, Grasonville, Md 21638 of Disposition (Name of Dete 20c. Location - City or Town, Stete 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 1 ☐ Burial 2XXCremetion 3 ☐ Removel from State Capitol Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 2/20/98 Dover, De. 21. Signeture of Funeral Service License 22. Name end Address of Fecility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland shock, or heart future. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 6-27-96 Examine Physician/Medical Examiner and i-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): physician ar Due to (or es a consequence of): as 980 23b. Did tobecco use contribute to the ceuse of deeth? Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert t. been signed by the should be detached 1 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? peen page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatlent 3 DOA this 28a. Dete of Injury (Month, Day Yeer) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? : After 1 1 Naturel 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu death. 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. Medical 2 Medical Examiner: On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed, (Month, Dey, Year) 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 509 Idlewild Ave. Easton, Maryland 21601 David smith, MD 31. Dete filed (Month, Day, Year) FEB 2 0 1998

32. Registrar's Signeture

Julia Davidson-Randoll

State

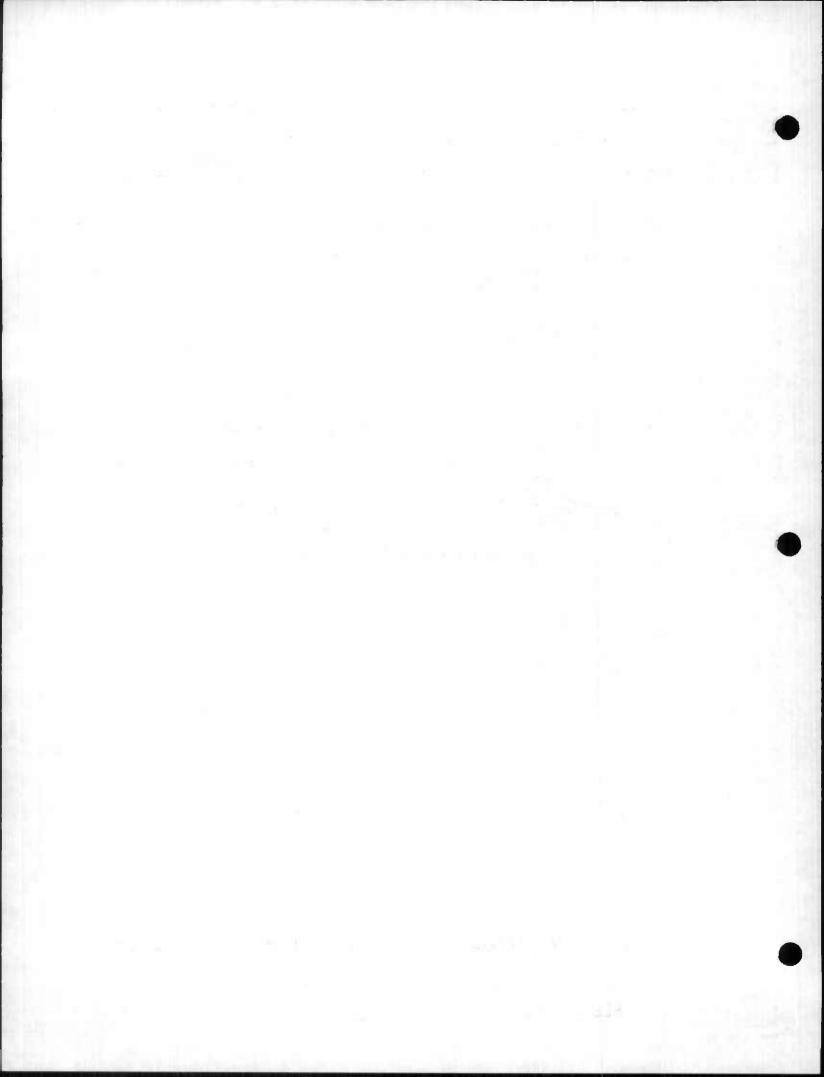
Registrar

obby Everett

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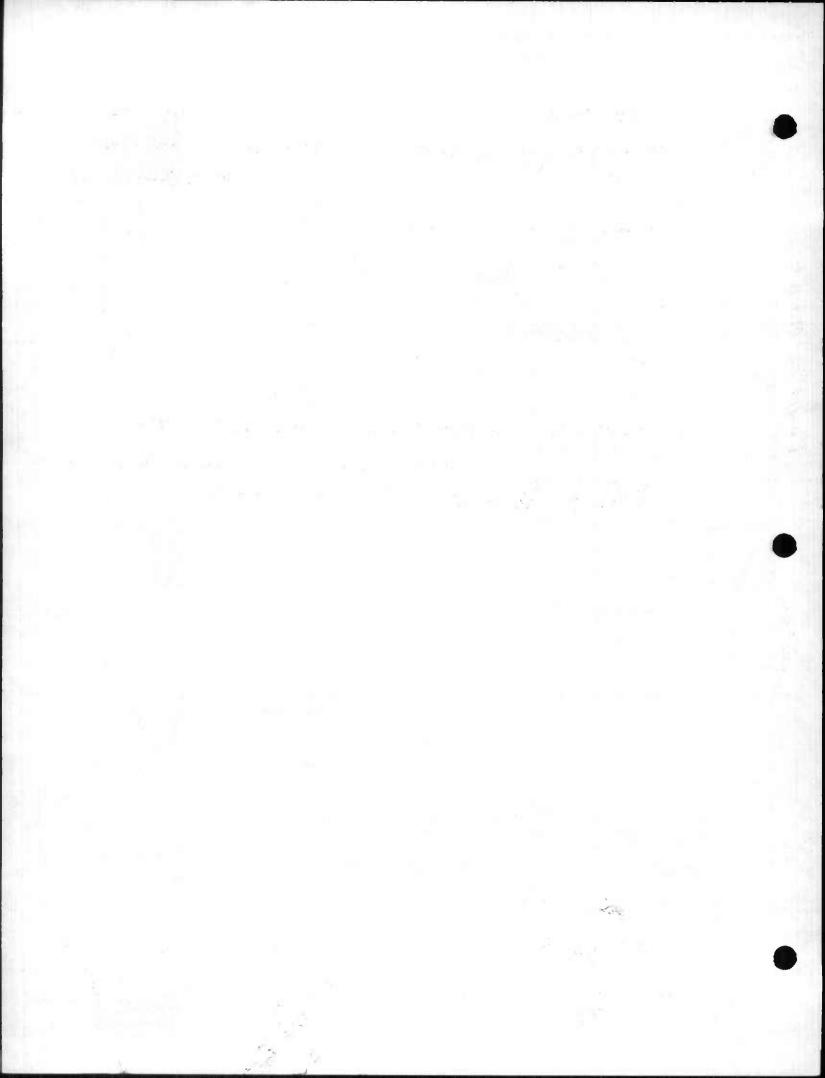
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DHMH 16 Rev 6/95

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Aanyla P sho	5								10	d. Inside City Limits 1 ☐ Yes 2 💆 No
the A	Director	Maryland Dorchester 10e. Street end Number	Cam	bridge	10f. Zip Code			10g. Citizen of	What Count	-
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icata be physicia s the bur	Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Lest	CARCLIAC Due to (or e	s a coneeq	uence of):	ymi A scleruti	c Dis	iens e		4 min 5 yrs.
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	-	30. Name and address of person who comp	pleted cause of deeth (item 2		Print)	6388 15, Hu	11		1	
		Michael trace	32. Registrer's Signatu 98 Sulia D	302	Collin	15 Hu	rlock	mal 2	162	5

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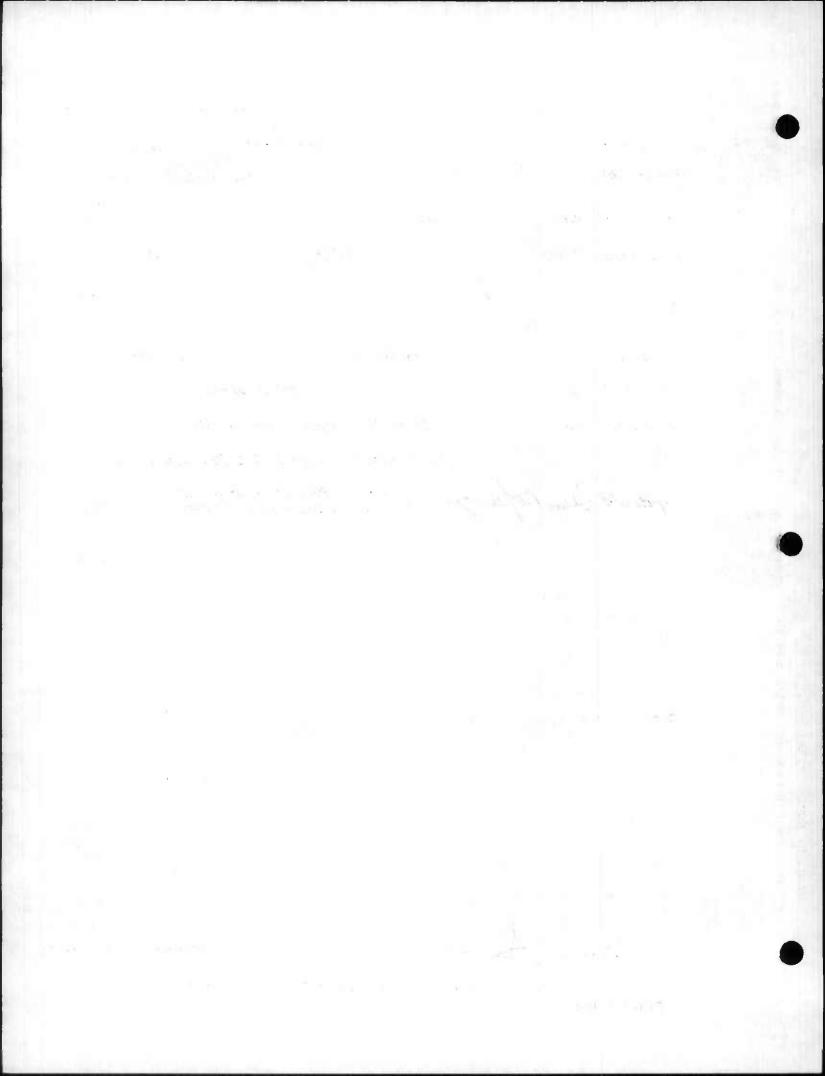


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lirector		172-18-9 Usual Residence		1□ M	2 ∏ F	81	Yrs.	Monti	hs Dey	Hours		y 19,		Penr	
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Hazel W. Moore



State of Maryland / Department of Health and Mental Hygiene

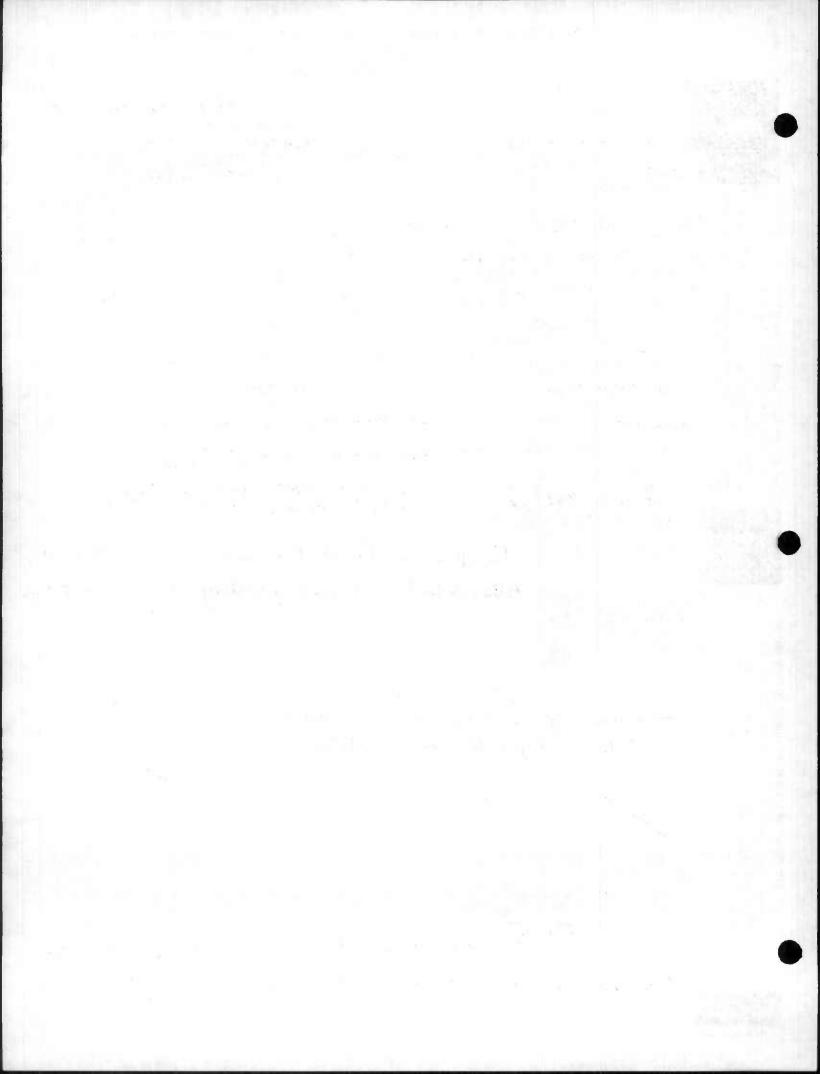
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** FEBRUARY 13 1998 05:30 EVELYN PATRICIA McKENZIE /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SACRED HEART HOSPITAL **CUMBERLAND** ALLEGANY 5. Sociel Security Number If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) **Funeral** 1□M 2X F Deys Hours Director 218 16 4036 Yrs. 73 MAR 17 1924 MARYLAND Usuel Residence of Decedent death with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ne 23a or 28a-f show Director 1 ☐ Yes 2 🛛 No MARYLAND GARRETT FROSTBURG 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20104 NATIONAL HIGHWAY, NW 21532 U.S. Funeral |temes 12. Wes Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed within 72 hours eftar 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married 21215-0020 6 þ 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Specify: "naturs!", WHITE Completed Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/industry Hyglana. Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME and Mantel Hygis Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Peges 1 end 2 should be fili-mant of Heelth and Mantel H-tant: If Item 27 is marked oth jury or other traumatic even Be CLARENCE RALEY BARBARA McKENZIE 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BARBARA MARTIN / DAUGHTER 1852 FINZEL ROAD, FROSTBURG, MD 21532 altimore. 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or FINZEL CEMETERY 2/16/98 FINZEL, MD 22. Neme end Address of Facility SOWERS FUNERAL HOME, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Onset end Deeth Physician /Medical Immediete Cause (Final RESPINATORY FAILURE ONE HOUR disease or condition resulting in deeth) Examiner Due to (or es e consequenca of): Examiner TWO YEARS CARCINOMA LUNG The law requires that tha daath certificate be axecuted Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Lest pue Due to (or es e consequence of): P.O. Box 68760, physician Physician/Medical Due to (or es e consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY ALSOMSE Records, þ page 2 should be Completed 24e. Wes en eutopsy performed? 24b. Were autopsy findings evellable prior to peen BIVENTRICULAR CONGESTIVE HEART FAILURE completion of cause of death? this certificate has CHRONIC OBSTRUCTIVE PULMONARY 1 Yes 2 NO 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: oftar death.

Director: After this certifica 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 funeral 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Hospital 12 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end pleca, end due to the cause(s) end menner stated. Medicai 29a. Certifier (Check only one) To the Vithin 2 29b. Signeture end title of 29c. License number 29d. Date signed (Month, Dey, Yeer) D33417 (MO.) FEBRUARY 13, 1998 loe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1068 NATIONAL HIGHWAY LAVALE, MANYLAND 21502 JAMES R. MOEN, MO 31. Dete filed (Month, Dey, Yeer) 12. Registrar's Signature State FEB 1 84998 Maudeonlibraus Registrar

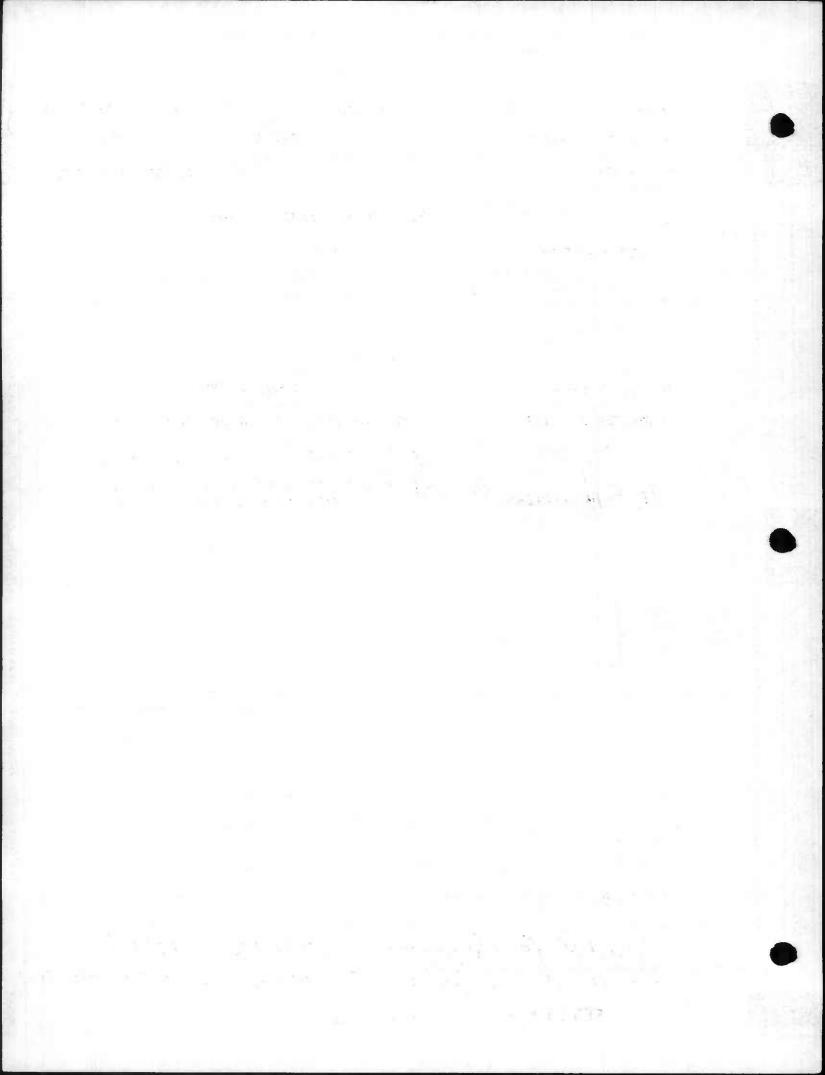
State of Maryland / Department of Health and Mental Hygiene 9 8

-					Cer	tificate of	Death	Re	g. No.	00001
	Dharata	•	1. Decedent's Name (First, Middle, Last)					2. Date of Deeth	1	3. Time of Deeth
	Physic /Medi		Calvin A. Nicol					Month Februa:	ry 15,199	8 11:00PM
	Exami		4e. Facility Name (If not institution, give street and num	nber)			4b. City, Town, or L		4c. County of De	
			Sacred Heart Hospital				Cumberlan	d	Allegany	7
	Funeral	г	5. Social Security Number 6. Sex	7. Age (In yrs. ia	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
Ġ.	Director		214-16-2485 1⊠ M 2□ F Usual Residence of Decedent	77	Yrs.	Working Days	TIOUTS INIT.	March 15	, 1920	MD
	ylan		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Ma a-f s	Director	MD Allegany	Fros	tburg					1 ☐ Yes 2X No
	th th	- E	10e. Street end Number			10f. Zip Code		10	g. Citizen of What	Country?
	th wil		17014 Old National Pike	S.W.		21532			USA	
	er dea	Funeral	11. Marital Status 12. Was Deca Armed For	dent Ever in U.S	i. 13. V	Wes Decedent of f Yes, specify Cub	Hispanic Origin? (Sp en, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Raca - An Biack, Wi	nericen Indian, nîte, etc.
Maryland 21215-0020	s 1 and 2 should be filed within 72 hours efter death with the Maryland if Health end Mentel Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Medical Evanther must be notified at	by	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes if Yes, Giv Year or Da	rces? WWII 2 No re ates: Army	1	I□Yes 2√2No	Specify:		Specify: [White
5	72 h	etec	15. Decedent's Education (Specify only highest grade completed)		/Give	lent's Usuai Occu	duning most of work	ina 1	6b. Kind of Busines	s/Industry
7	within ene. than	Completed	Elementary/Secondery (0-12) College (1	-4or 5+)	life. L	OO NOT use retire	ed)	9		
7	filed with Hygiene. rther than	S	7 0		Labo	rer			Tire	
ב	tei H	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	lalden Sumame)	
Ya	should be nd Mentel merked o	2	James Andrew Nicol				Dolly Syn			
Za	2 sho		19a. tnformant's Name/Reletionship (Type, Print)				t and Number or Rur			, Zip Code)
d)	1 and Health em 27		Dale Nicol Son				reet, Her			
Baltimore,	permit. Peges 1 an Department of Heal important: If item 2 any injury or other once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from 5	20b. Pla	netery, crem	sition (Name of natory or other pla	ice)		Oc. Location - City of	or Town, State
	Pent:		4 ☐ Donetion 5 ☐ Other (Specify)	Rest	Lawn	Memoria	Gardens		aVale, M	
ž	Depart Import any In		21. Signeture of Funeral Service Licensee			. Neme and Addre				
ш	20.5 2 3		Jans E. Meken		E1	.cnnorn-N	AcKenzie F	uneral H	lome P.A.	: 20
П			23a. Parri. Enter the disease, or complications that constructions that constructions or heart feilure. List only one cause on expectations.	aused the death.	Do not ente	er the mode of dyl	ng, such as cerdiac	or respiretory erre	g, MD ZI.	Approximete interval Between
	Physician									
	/Medical		immediate Cause (Finel disease or condition	made	Live.	hear	+ For O	lad P.		3 years
	Examiner		resulting in death)	Due to (or	as a conseq	uence of):				
	D #	Examiner	- Alt	io mosel	enstre	Con	onany C	Interry	Disters	3 years
	rificete be executed ng physician end es the buriel-transit	хап	Sequentially list conditions,	Due to (or	as a conseq	uence of):	0	J	•	
6876U,	clan		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.							
00	ohysi the t	edicai	that initieted events resulting in death) Last	Due to (or a	as e consequ	uenca of):				
D X	E 00	2	d							
POX	eath ce attendir	lan	- 3.							
	the a	Physician/	Part ii. Other significant conditions contributing to de-	ath but not result	ting in the un	iderlying ceuse gi	ven in Part i.	23b. Did tob	acco use contribu	te to the cause of death?
, r.	The law requires thet the death ce ate hes been signed by the attendi pege 2 should be deteched for use	by Ph	Carecnoma of Po	mere	ose -	D'a Cop	bales	1 □ Ye	8 2□No 3₽	Probably 4 Unknown
ë	quire an sig		. 00 =	1-0	_	0 .0		24a. Was an		. Were autopsy findings evelleble prior to
Hecords,	aw re	Completed	mollins - Types	Muso	~ _	COP	\sim	perform	907	completion of cause of deeth?
ř	ilcian: The lav certificate hes rector, pege 2	Eo						1 □ Yes	2 DNO	1 ☐ Yes 2 ☐ No
<u>a</u>	an: tifica tor, p	0	25. Was case referred to medical				26 Place of Deat	(Check only one		
_	Attending Physician: The Indepth. ector: After this certificate he by the funeral director, pege	To B	examiner? 1 ☐ Yes 2 ☑ No Hospitai: 1 ☑ Ir	npatient 2 E	R/Outpatient	3□ DOA Ot	her:		nce 6 Other (Sp	pecify)
0	g Ph er th		27. Manner of Deeth 28e. Dete o	of Injury h, Day Year)	28b. Time of injury	28c. Inju Wo		28d. Describe hov		
0	ttendin deeth. ctor: Afi y the fu	atic	1 ☑Netural 5 ☐ Pending (Mont/ 2 ☐ Accident investigation	., Day 70a.)	injury		Yes 2□No			
DIVISION OF VITAL	er de	ertification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place buildin	of tnjury - At hom	ne, farm, stre	et, factory, offica		28f. Location (Stre		Rural Route Number,
בֿ	rs eft el Dir	Cer		(Opouny)				,		
	To the Hospital or Attending Phys within 24 hours eldeelth. To the Funerel Director After this completely filled in by the funeral di	edical	29a. Certifier (Check only 2 Medical Examiner: On the ba	best of my knowl	ledge, deeth	occurred et the ti	me, date and place,	and due to the car	use(s) and menner	es steted.
	the H		one) and mann	er steted.	GROWOI IIIV					
	To To To	Σ	29b. Signature end title of certifier	1.4		29c. Licens			d. Date signed (Mo	nth, Day, Year)
	7) (da	nellur	. MO	DI	4464	F	ebruary (6 , 1998
	4.0		30. Name and address of person who completed cause	of death (Item 2	23e) (Type, F	Print)		+	1	
	nes		Schander Sandher	- M.D.	48	Tarnt	errace	trost	Jura 14	1 21532
	Sta	ite	31. Date filed (Month, Day, Year) 38, Re	edistrar's Signatu	ire)	



State of Maryland / Department of Health and Mental Hygiene

•		Decedent's Name (First, Middle, Last)		Certifica	e or	Deali	2. Data of De			3. Time of Death
Physic		JANE	W.		MET	TAO		Month FEB.	Day	Year 1998	1:25a.
/Medi Exami		4a. Facility Nama (If not Institution, give			NELS		4b. City, Town, or L				1:23a.1
EXMITI	riei	WILLIAM HILL MAN					EASTON			ALBOT	
Funeral Director			7. Age (87	(In yrs. last birth Yı	Months	n 1 Yaar Days	If Undar 24 Hrs. Hours Min.	8. Date of Bird (Month, Da FEB • 2	h y, Year) 7, 1909	9. Birthpl Count MAR	ace (Stete or Foreigny) YLAND
ahow dat		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location			A CERONA		10	od. fnside City Limi
Ne M	acto	MD TALB	01				E.	ASTON			1X Yas 2□N
23a or 2	Funeral Director	10e. Street and Number 501 DUTCHMAN S LA	NE		10f. Zij	2160	01		10g. Cifizan of V USA	What Count	iry?
filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or ferms 23a or 28a-f ahow ont, tre Medical Expander must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Ev Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates:	ar In U,S.	13. Was Dece ff Yas, spe 1 ☐ Yes		dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specify	e - America ck, White, e :: WHIT]	etc.
d within 72 hours a giene, or then "natural", o	Completed	15. Decedent's Edu (Specify only highast grad Eiementary/Secondary (0-12)	cation e completed) Coilaga (1-4or 5+)				pation during most of work d)	ing	16b. Kind of Bu	usiness/Ind	
o filed vi offher I		17. Father'a Nama (First, Middle, Last)		Н	OUSEWI	FE	18. Mother's Nam	a /First Middle	OWN HO		
S ta b x	To Be	WILLIAM S. WILSON						A COVEY	Meloen Sunian	10)	
2 6 8 6		19a. Informant's Name/Relationship (Ty CHRISTOPHER D.W. N			_		end Number or Rui				Code)
Heal Hem 2 other		20a. Method of Disposition 1 Burial 2 Cremation 3 F		20b. Place of E cemetery,	isposition (Ne crematory or	ne of other pla	THUR RD,	Date	20c. Location -		vn, State
Pages ment of ant: If he ury or o		4 Donation 5 Other (Specify)		CHESAPE	AKE CRE	MAT	ION	2-10	CHESTER	R, MD	
permit. Pages Depertment of Important: If it any injury or once.		21. Signature of Funeral Service License	on UI.	CFSP	FELLOV	IS, I	ess of Facility HELFENBEI RRISON ST				HOME, P.
Physician /Medical Examiner	J.	23a. Part1. Enter the disaase, or complishock, or heart failure. List only or immediate Cause (Final disaase or condition resulting in death)	Me.	tastas ue to (or as a co	h'c	1	icast				Approximate Intervel Between Onset and Death
ificate be executed g physician and as the buriel-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last		ue to (or as a co							
5 0 6	-		l	<u> </u>							
y the	Physician/N	Part II. Other signiffcant conditions con	tributing to death but i	not resulting in the	ne underlying (ause giv	ren in Part I.	23b. Did t	(1)		the cause of deat
requiras een sign hould be	by								en eutopsy med?	ava	re autopsy findings llable prior to apletion of causa eath?
The law cata has b	Completed							101	es 200 No		Yes 2□ No
ysician: The	Be	25. Was case referred to medical axaminer?	lospital:			Oth	26. Place of Deat				
	2	1 ☐ Yes 280 No	1 ☐ Inpatiant 28a. Date of Injury	2 ER/Outp		DA	(4E) Nursing Ho		lence 6 Oth)
leath. lor: After the fune	Certification:	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Dey Y	(ear) fnju	M		k? Yes 2 □ No				
To the Hospital or Attending Physical Wiltin 24 bours after death. To the Funeral Director: After this complately filled in by the funeral di		4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm (Specify)	, streat, factor	, office		28f. Location (S City or Tox	Street end Numb m, Stete)	er or Rurel	Houte Number,
he Hosp in 24 hot he Fune plataly fil	edical	29a. Certifier (Check only one) Certifying Physical Examination	fcian: To the best of ner: On the besis of exand manner state	camination and/c	leeth occurred or investigation	at the tir , in my o	ne, date and plece, pinion, death occur	end due to the d red at the time, d	cause(s) end me date and place, a	enner es sta and due to	ited. the cause(s)
with Tot	M	29b. Signature and title of certifier	A Ru	vix	29	1	428 /	/	29d. Date signed	100	
		30. Name and address of person who co	17	th (Item 23a) (Ty	pe, Print)	<u></u>	ntchmans	1 m	EASH	n r	nn 2/60
	te	31. Data filed (Month, Dey, Year)	32. Registraf4	1			, 110	W.C	_		

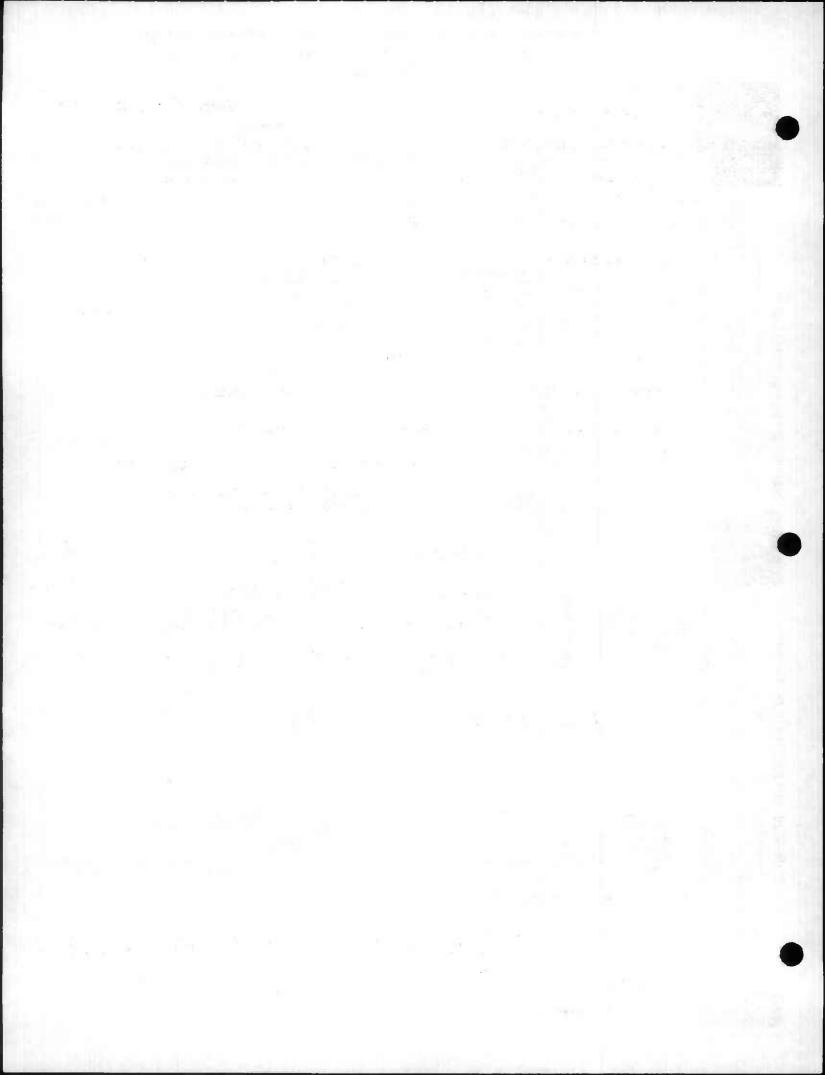


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death FEBRUARY 21 1998 **Physician** 1717 Laura W. O'Haver /Medicai 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland
| If Undar 24 Hrs. | 8
| Hours | Min. Allegany If Under 1 Year Months Days 9. Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Date of Birth (Month, Dey, Yaar) **Funeral** 10 M 20 F Yrs Director 234-64-3582 82 Apr 10, 1915 WV Usual Rasidance of Decedan the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director Allegany Rawlings 10a. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 23302 Placid Lane SW 21557 USA Funeral 14. Race - Amarican Indien, Black, Whita, atc. 12. Wes Dacedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 72 hours eftar 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Datas: 1 Navar Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 🎾 ☐ No Specify à 3. Widowad 4 Divorced white Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind ot Businass/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) 12 Homemaker Own Home 17. Fethar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Malden Surnama) Be James W. Crabtree Emma F. (Kerns) 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) Lee O'Haver-son P.O. Box 312 Rawlings MD 21557 20b. Place of Disposition (Nama of cemetary, crametory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial 02/26 Keyser WV 21. Signature of Funeral Sarvice Licanses 22. Nama and Addrass of Facility Scarpelli Funeral Home, P.A. 23a. Pert1. Entar the disease, or combilications that caused the down to not enter the mode of dying, such es cardiac or respiretory errast, shock, or haert feilura. List only one cause on aech inn. Approximata Interval Between Onset and Deeth **Physician** /Medical Immadiata Ceuse (Final disaasa or condition resulting In daeth) were Examiner Dua to (or as a consequence of) physician and the burial-transit The law requires that the death cartificate be executed Sequantially list conditions, if any, leeding to immadiate causa. Enter Undarlying Causa (Disaese or injury thet initioled avants rasulting in daath) Last Due to (or es a consequance ot) Box 68760 Physician/Medical Dua to (or es e consequence of) 88 usa ō Pert II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. tha s been signed by ta should be datach 1 Yes 28 No 3 Probably 4 ☐ Unknown ģ 24b. Wara autopsy findings availabla prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed page 2 s hes 1 ☐ Yas 200 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, 25. Wes casa rafarrad to medical axaminer?
1 ☐ Yas 2♥ No Be 28. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) Certification: To 1 inpatiant 2 □ ER/Outpetient 3 □ DOA 27. Magnar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 1 Natural
2 Accident 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 6 Could not be datarminad 3 Sulcide 28t. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred et the tima, dete and place, end due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) end mannar stated. 29a. Cartifiar Medical (Check only one) 29d. Date signed (Month, Day, Yaar) 10 dress of person who completed Drive Cumberland MD 21502 ohn Mehanna Registrar

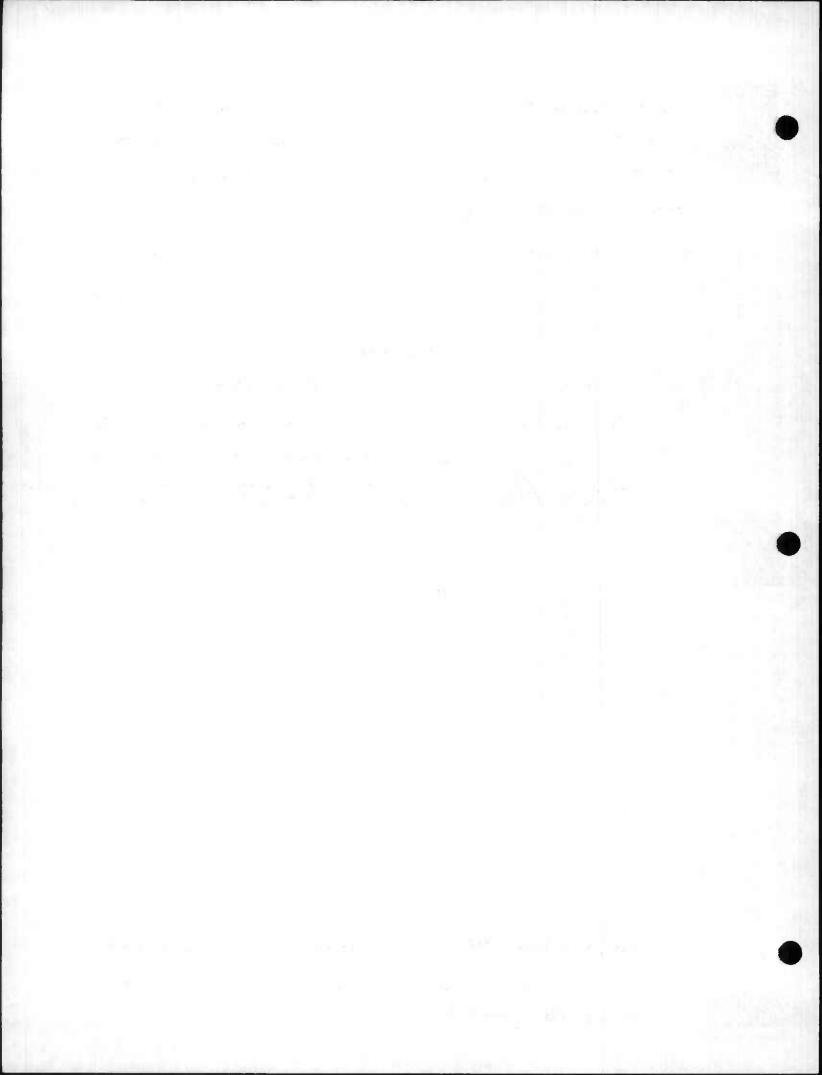


State of Maryland / Department of Health and Mental Hygiene Q

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	Dhueis	1	1. Decedent's Name (First, Middle							2. Dete of Month	Deeth	Dey	Yeer	3. Tim	ne of Deeth
	Physic /Medi		Eleanor Homil	ler Ong						Feb.	14,				5:15PM
) .	Exami		4e. Fecility Name (If not institution						4b. City, Town,	or Location of De	eth	4c. County	of Deeth		
			Manor Care-Sp		se				Bethesda				gomer	У	
	Funeral Director		5. Social Security Number 578–44–7507 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ₹ F	7. Age (In yrs 100			Under 1 Year onths Deys			Birth Dey, Ye 12,	ar) L897	9. Birthp Coun Wash	iece (State) ingt	tete or Foreign
	Maryland -f show	tor	10e. State 10b. County Maryland Montg	omery		ity, Town	or Location	on					1		de City Limits
	with the	Director	10e. Street end Number 5101 Ridgefield	Road				0f. Zip Code 20816				Citizen of \	Whet Cour	itry?	
	ns 23	era	11. Marital Status		cedent Ever in	1.S			Hispenic Orlgin?	(Specify Yes or			e - Americ	en Indie	en.
020	d within 72 hours effer death with the Maryland idene. Than "natural", or items 23a or 28a-f show than Medical Examined than the Invitred to the first than Medical Examined.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed 1	Forces? 2 2 No Sive	0,0		s, specify Cut Yes 21 No	Hispenic Origin? pan, Mexican, Pu Specify:	erto Ricen, etc.)		Blad	ck, White, v: Whi	etc.	
ה ה	72 h	ted	15. Deceden (Specify only higher	's Education	0	16e.	Decedent'	s Usuel Occu	petion	vorkina	16b	. Kind of B	usiness/Ind	dustry	
	within ene. then "	Completed	Elementery/Secondary (0-12)		(1-4or 5+)		nemak		during most of ward)	roiking	Or	vn Hor	ne.		
5	· 호 첫 홈 년		17. Fether's Neme (First, Middle,	Last)		1101	nemar		18. Mother's N	lame (First, Mid	1 .				
20	O TO O	To Be	Charles Homille	r					Blanche						
ary	d 2 should I th end Meni 7 is marked traumstic	-	19e. Informent's Name/Reletions	hip (Type, Print)		19b.	Mailing A	ddress (Stree	t end Number or	Rurel Route Nu	mber, Ci	ty or Town,	Stete, Zip	Code)	
2	os 1 and 2 of Health e item 27 is other trac		Harry Alfred On	g, Jr.		196	60 Li	ncoln	Drive, S	Sarasota	, FI	Corida	a 343	26	
Baltimore,	permit. Peges 1 and Depertment of Health Important: If item 27 any injury or other tr once.	i	20e. Method of Disposition 1 Dariel 2 Cremation 4 Donetion 5 Other (S)		n State Ar	Plece of cemeter,	Disposition, cremeto	n (Neme of ory or other ple Nation	al Cem.	Dete 2/26/98		Location -			te
Dail	Depentit. Depentit Importa any inju		21. Signeture of Funeral Service	Licensee Lete	id)			-	ess of Facility Wler's S		c. 5	130 W	I Av	enue	, N.W.
(400	2	23a. Part1. Et rittle disease, or shock, or een feilure. List	1-		ith. Do n					y errest,			Approx	l Between
	Physician /Medical		Immediate Ceuse (Final disease or condition		Arter	iosc	lerot	ic Hea	rt Disea	ase			1	.5 ye	end Deeth
	Examiner		resulting in deeth)	ө.	Due to	or es e c	onsequen	ce of):							
-	D #	iner			Hyper	tens	ion						2	0 ye	ars
Ď.	icate be executed physician end s the burial-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	S	Due to	or es e c	onsequen	ce of):							П
x 00/00,	2 00	Medical	thet initiated events resulting in deeth) Lest	d	Due to (or es e c	onsequenc	ce of):							
.O. DOX	thet the death ce led by the ettendir detached for use	Physician	Part II. Other significant condition	ns contributing to	death but not re	sulting in	the under	tying ceuse g	ven in Pert I.	23b. D	id tobe	co use co	ntribute to	the cer	uee of deeth
L	res thet ti iigned by be detac	by Ph								- 1	☐ Yes	2⊠ No	3 🗆 Prol	oably	4 Unknov
or vital necords,	aw requi	Completed									es en er		eve	ellable p	psy findings prior to n of cause
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2	certificete rector, pag	Be	25. Wes case referred to medical						26. Place of D	eath (Check on	ly one)				
-	5 00 0	To	examiner? 1 ☐ Yes 2]∑ No	Hospital: 1	inpatient 2] ER/Out	petient 3	DOA Ot	her: 4X Nursing	Home 5 ☐ R	esidence	6 □Oth	er (Specif	y)	
	Ing Phys I. After this funeral di		27. Manner of Death 1 X Naturei 5 ☐ Pendin 2 ☐ Accident investig	ation	of Injury nth, Dey Year)	28b. T	jury	28c. Inju Wo M 1	nyet nrk?]Yes 2 ☐ No	28d. Descri	oe how i	njury occur	red		
5	tal or Attend rs efter death al Director: /	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 256. Plea	e of Injury - At I ding, etc. (Spec	nome, far ify)	m, street,	fectory, office		28f. Locatio City or	n (Street Town, St		per or Rura	/ Route	Number,
	ne Hoapital n 24 hours e ne Funeral I pletely filled	edicai		Physicien: To the Exeminer: On the end me											1 se (s)
	To the within 2 To the F Complet	Σ	29b. Signature end title of certifie					29c. Licen			29d.	Date signe	d (Month,	Dey, Ye	er)
1	0		Yhila K.	formes	M.D.			717	8		2.	16	98		
1	v		30. Neme end eddress of person												-
			Phillip R. Ja 31. Date filed (Month, Dey, Year)		54 Registrar's Sign	O1 W	este	rn Ave	Che	vy Chas	e. M	D 208	315		
	Sta Registi		FEB 19 1		ha Devido	A-M	ndell.								

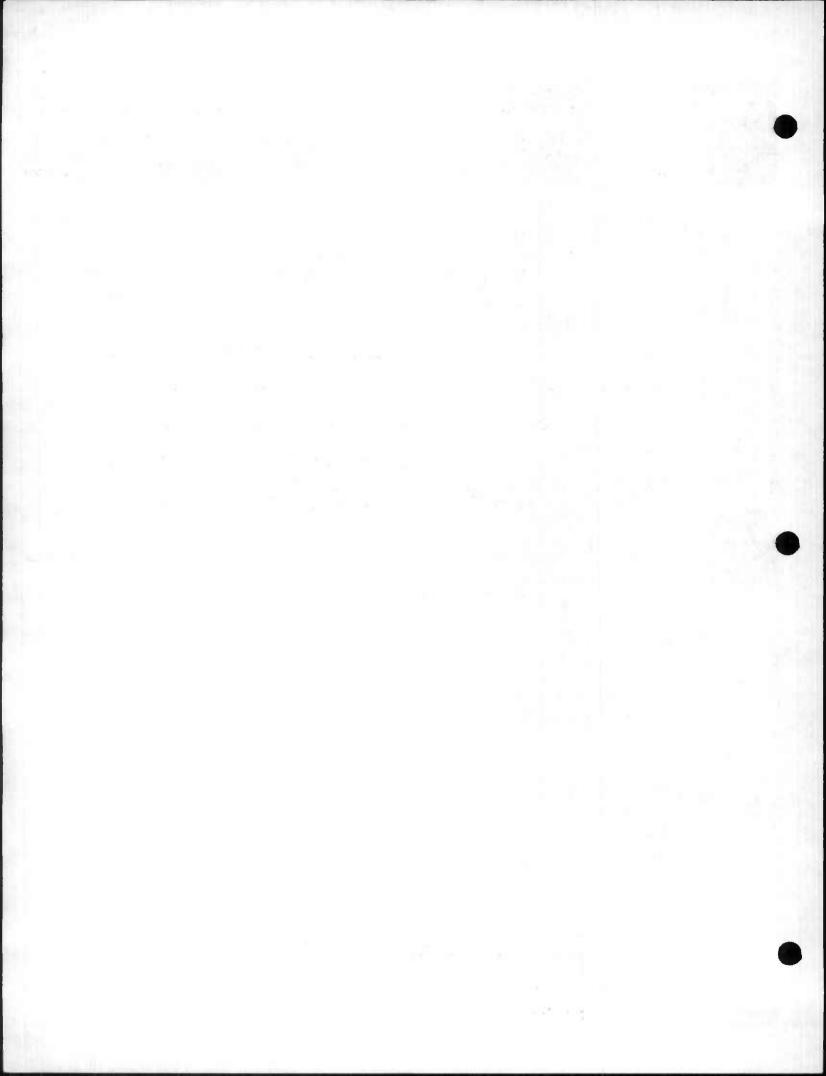
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** BRUCE STANLEY February 20, 1998 7:55 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Southern Maryland Hospital Prince Georges Clinton 8. Date of Birth Sept. 6, 1960 9. Birthplece (State or Foreig Country) Washington DC 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 CM 2 F Deys Hours 37 Yrs. 213-86-7303 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow 1 ☐ Yes XX No Directo Maryland Charles Waldorf 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Peges 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itama 23s or any Injury or other treumstic event, the Medical Examines must be no 9820 Bunker Hill Road 20603 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2X No If Yes, Give Yeer or Dates: 1X Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ¥ No Specify: Specify: White P 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Air Condition & Heat Technician A/C & Heat 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Juanita G. Raines Charles L. Owens 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Juanita Owens-Mother 1600 Airport Lane, Accokeek, MD 20607 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetlon 3 Removel from Stete 4 Donation 5 Other (Specify) Trinity Memorial Gardens2-25-98 Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Shannon Ramirez M00798 Huntt Funeral Home, Inc. Snannon Raminez M00798 P. O. Box 156, Waldorf, MD 20604-0156

23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final 48 hrs SEPSIS disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner INTRA ABDOMINAL INFECTION requires that the death certificate be executed physician and the burial-transi Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) 98 USB for signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No RESPIRATORY FAILURE þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed ate hes page 2 s 1 ☐ Yes 2 No 1 Yes 2 No certificate or Attending Physician: after death. Director: After this certifice director. 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Wo 1 Nnpatient 2 ER/Outpetient 3 DOA 2 funeral 27. Menner of Deeth 1 Deeth 28e. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 29e. Certifier edical 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the besis of examinetion and/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner steted. within 2 To the the 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certified 0 D29646 February 21, 1998 MD.P.C kwchano 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Joel Sewchand, P. O. Box 975, La Plata, MD 20646 31. Dete filed (Month, Day, Yeer) F.EB 2 3 1998 32. Registrar's Signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle Last) 2. Data of Death 3. Tima of Deeth **Physician** Month James Manley 0wen February 1998 11:15 AM 14 /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown
If Undar 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Mary s

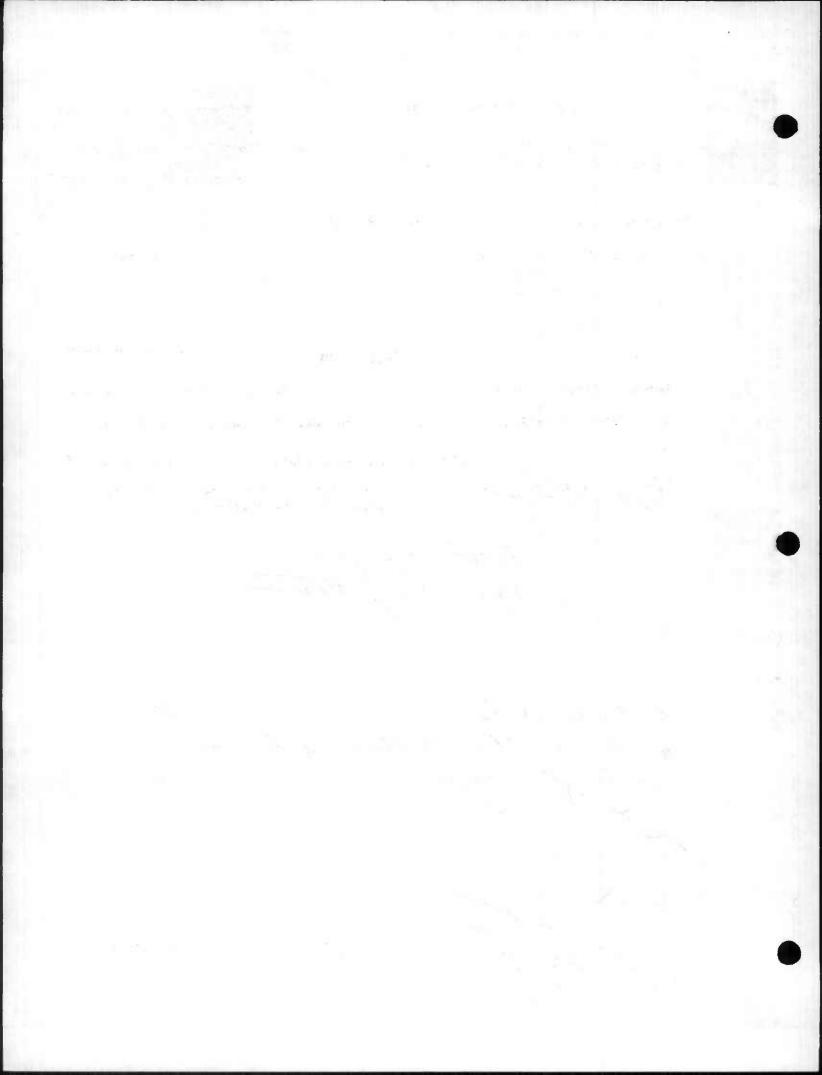
9. Birthplaca (Stata or Foreign Country) If Undar 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 1 □XM 2 □ F Days 240-24-0373 77 Yrs. Director June 20, 1920 North Carolina Usual Rasidanca of Decadant the Meryland 10a State 10b County 10c. City, Town or Location ral', or items 23s or 28s-f show Examiner must be notified at 10d. Insida City Limits 1 Yas 2 No Director Maryland St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? filed within 72 hours after death with 29449 Charlotte Hall Road U.S.A. Funerai 12. Was Dacadant Evar In U,S. Armed Forcas? 1 □XYas 2 □ No tf Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amaricen Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 21215-0020 "natural', or 1 Yas 2 No Specify: Completed by Specify White 3 XWidowad 4 ☐ Divorcad the Medical 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department Store 7th Electrician 7 Is marked other traumatic event. Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be Peges 1 end 2 should be nent of Health end Mentel James Purdie Owen Bessie Miranda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Depertment of Health e Important: If Item 27 Is any Injury or other tra-James Michael Owen/Son 27879 Chapel Ct., Mechanicsville, MD 20659 20b. Place of Disposition (Nama of cematary, crematory or othar place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens | 2/18/98 | Leonardtown, MD 22. Nama and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 shock, or haart failura. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical tmmediata Cause (Final disaasa or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata ceusa. Entar Undarlying Cause (Diseasa or Injury that initieted avants rasulting in death) Lest for use as the burial-tran Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): signed by the ettending Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 3 ☐ Probably 4 ☐ Unknown 2 director, page 2 should Be Completed 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy After this certificate has 1□ Yes or Attending Physician: 25. Was cesa referred to med 26. Place of Death (Check only one) axaminar? Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) Certification: To 1 Yas 2□ER/Outpatient 3□ DOA the funeral 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Insury at Work? 5 Pending investigation Natural death. 2 DNd 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director:. 6 Could not ba 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of any inowledge, death occurred at the time, date and place, and due to the causa(s) and mennar as stated.

Redical Examiner: On the bast of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. Licansa numbar 29d. Data signad (Month, Day, Yaar) 30. Name and address of pes causa of daath (Item 23a) (Type, Print) JAMES C. BOXE M.D. D50 WILDWOOD CTR. CALIFORINA, MD. 20619 Molistrage Stevatura Randall

DHMH 16 Rev 6/95

State Registrar

OWEN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Alice O'Brien M. Feb 1998 11 11:35 AM /Medical 4a. Facility Nama (If not institution, giva straet and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Genesis ElderCare -The Pines Easton Talbot If Under 1 Yaer If Undar 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthplece (Stata or Foreign Country) **Funeral** Months Deys 1□M 2XF Hours 026-30-0346 **Director** 92 Aug. 14, 1906 Boston, Mass. Usual Residence of Decedent with the Marylend 10e. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Heelih and Mental Hyglene. Important: If item 27 is marked other then "natural", or item 27 is or 28a-f show any injury or other traumatic event, fire Medical Examine (mail be notified at any injury or other traumatic event, fire Medical Examine (mail be notified at 10d. tnside City Limits 1 ☐ Yes 2 No Directo Maryland Talbot Bozman 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 23788 Ebb Point Rd. 21612 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritei Stetus 14. Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give X Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No by Specify: White 3X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Artist Self Employed 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumama) Be Joseph M. Levi Elizabeth Leech 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) r P.O. Box 296 Bozman, Maryland

20b. Place of Disposition (Name of cametery, cremetory or other place)

Dete 21612 Alice Jane Lippson Daughter 20e. Method of Disposition

1 Burial 2 Cremation 3 Removel from State 20c. Location - City or Town, Steta Marshfield Cemetery Feb. 14, 1998 Marshfield, Mass. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture # Funaral Service Licensee 22. Nama end Address of Fecility Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663 naca 23a. Pert1. Enter the disaase, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiretory errest, shock, or heert feiture. List only one ceuse on eech line. Approximete Intervel Between Onsat and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in daeth) Examiner Dua to (or es e consequence of) Examiner physician and the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting In deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequança of): 80 esn detached for Pert II. Other significant condittons contributing to death but not resulting in the underlying cause given in Pert I. the th 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown PRESSION) Division of Vital Records. by 24b. Were eutopsy findings aveileble prior to completion of causa of deeth? 24a. Wes en eutopsy performed? BLADDER CANCER Completed peeu has page 2 1 ☐ Yes 2 ₺ No 2 12 No After this certificate 25. Wes casa referred to medical examiner? To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific Be 26. Piace of Deeth (Check only one) 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Yeer) 28c. Injury et Work? 1 Neturel 5 Pending 1 Yes 2 No investigetion 2 Accident the 6 Could not be 3 Sulcida 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide The Certifying Physician: To the best of/my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner as steted.

| Medical Examiner: On the cause of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) and mander stated. 29a. Certifier Medical completely 29b. Signeture and title of cent 29c. Licanse numbar 29d Dativisioned (Month, Day, Yeer) MAKAS MADO 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) E. MAKAS SO 8 FREWILD AUE EASTON, MD DO DANIEL

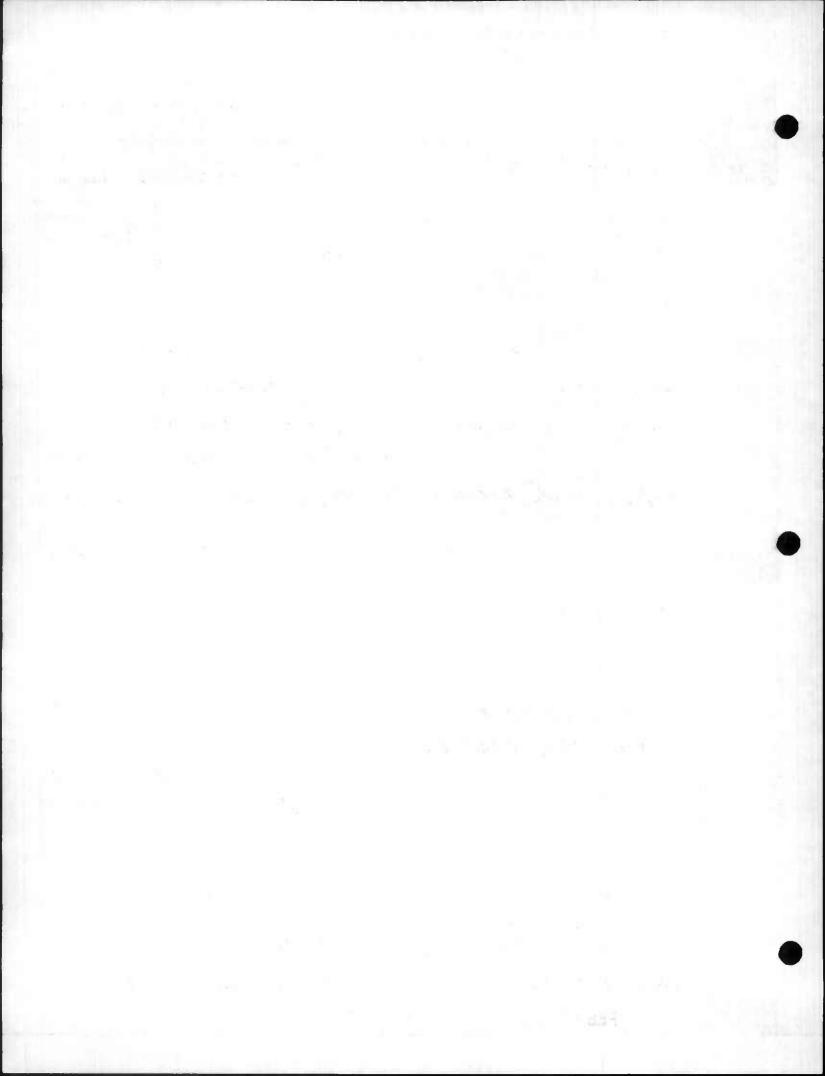
State Registrar

31. Date filed (Month, Dey, Year)

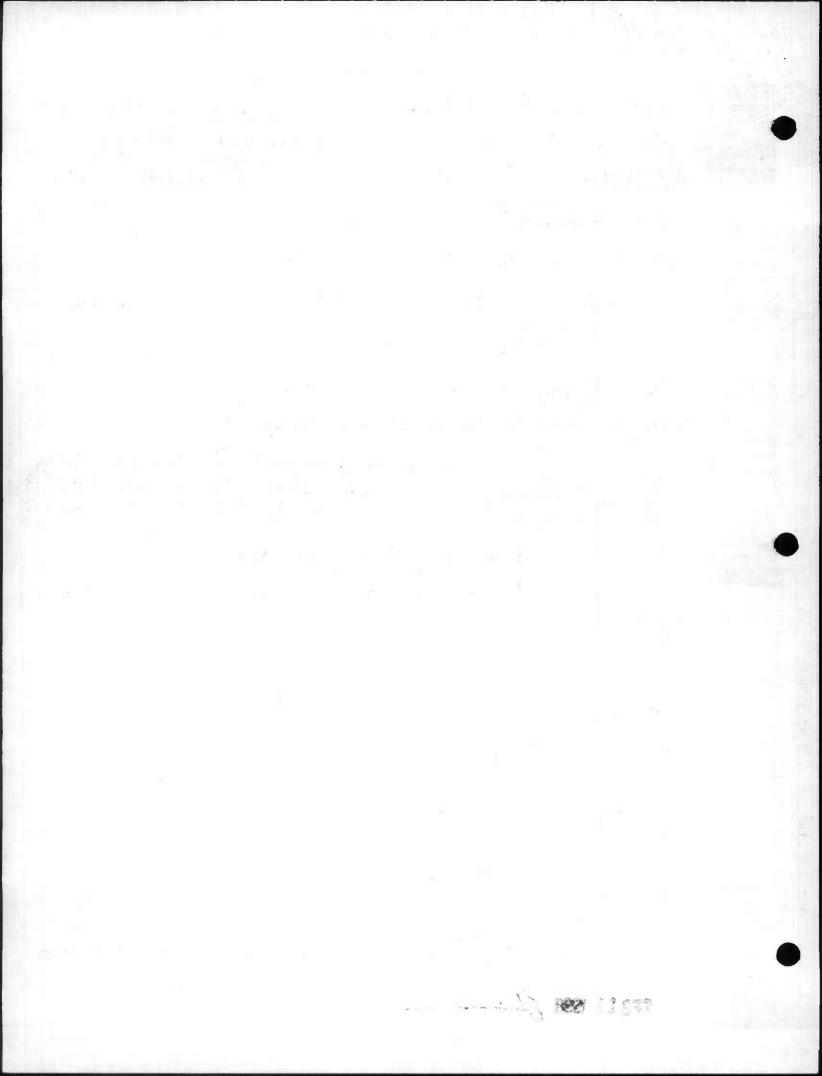
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32. Registrar's Signeture

- lia Davidson



1	Any	indel =	#	Please Type or Print in Black Indelible Ink. Assure A		_	ble.	
0	2/	11/90	1	State of Maryland / Department of Health and N Certificate of Death		70	068	364
L	00	114-7	.=	1. Decedent's Neme (First, Middle, Last)	2. Date of Death			ime of Deeth
		Physic /Medi		Ruth Elizabeth Owens	Feb.	-	998	1931
		Exami	ner	4e. Fecility Nama (If not institution, give street and number) Memoria Hospital Cumber	land	4c. County	of Deeth	
	T	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear)	9. Birthplace (Country)	Stete or Foreign
	h	Director		Usual Residence of Decedent	June 13,	1920	/	עוע
		filed within 72 hours efter death with the Maryland Hygiena. ther than "naturel", or items 23e or 28e-f show but, the Medical Evaninet must be notified as	5	MD Allegany. Barton				Side City Limits ☐ Yes 2 No
		or 28s	Funeral Director	10e. Street and Number 10f. Zip Code	10g.	Citizan of V	Vhat Country?	
		s 23e or	erai D	3012 Pine Swamp KD 21521		U	SA	
	0	urs eftar dea el', or items Examiner m	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 20 Married 1 Never Married 2 Named Forces? 1 Yes 2 No	ecify Yes or No- Rican, etc.)		e - American Ind k, White, etc.	lian,
	0050	72 hours e "naturel", o	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Dates:		Specify	VV III I	e
	21215-0020	in 72 t	Completed	15. Decedent's Education (Specify only highest grada completed) Elementary/Secondery (0-12) College (1-4or 5+) College (1-4or 5+)	sing 16t	. Kind of Bu	usiness/Industry	
		e filed withing the Hygiena.		8 0 Clerk	J	ewel	ry St	ore
	lanc	ld be filec ental Hyg ked other ic event,	To Be	John Milton Dowell 18. Mother's Nam	e (First, Middle, Mal	den Sumem N € √	ne) /	
	Maryland	1 and 2 should be f Health and Mental P om 27 le marked of ther traumatic eve	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			Stete, Zip Code)
		1 and 1ealth om 27 ther tu		Kandolph P. Chuens JR. hysbard 3012 Pine Dwamp 20a. Mathod of Disposition (Neme of	RD Ba		City or Town, S	1521 lata
	altimore,	Pages nent of I int: If ite		1 MBurial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Commetery, cremetory or other piece) Southern Memorial Cardens	1998 I	Dunki	rk, N	D
	Balt	permit. Pages Depertment of Important: If It any Injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	e Funero	1 Ho	me P.I	7
		UD = 0 0	H	23a. Pert Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac	onaconina	. M		539 eximete
4		Physician		shock, or heert fellure. List only one cause on each line.			inter	val Between it and Death
	1	/Medical Examiner	L	Immediate Ceuse (Final disease or condition resulting in death) a. CORNARY DEPORT DESCRIPTION OF THE PROPERTY DES	E		UNF	Ruger
	L	P #	miner	Due to (or as a consequence of):	,		IINI	MUGHY
		The law requires that the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the buriel-transit	Exam	Sequentially list conditions, if any, leading to immediate				1100011
	68760,	cate be en physicien s the burie		if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consaquance of):				
	39 X	certifica ding ph se es ti	Physician/Medical	d.				
3256	Box.	death certif e attending id for use e	slcian	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did toba	CCO UAR CO	ntribute to the o	ause of death?
	P.O.	that the death certific ed by the attending p detached for use es		Modria	1 □ Yes	2.05No		4 🗆 Unknown
7 32	Records,	quiras that n signed I uld be det	ed by	11.65	24a. Was en e	utopsy	24b. Were au	topsy findings
217	eco	a law requir has been s ge 2 should	Completed	the shastith soig &w	performed	17	eveileble completi of death	on of cause
	al B	iclen: Tha certificate h rector, page			1 ☐ Yes	2 D No	1 ☐ Yes	2□ No
	f Vital	Physicien: rthis certific rral director,	To Be	examiner? Hospital:	th (Check only one) ome 5 - Residence	9 8 □Oth	er (Specify)	
RUTH	on of	g 9		27. Menner of Deeth 1 → Naturel 5 □ Pending 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury Work? 28c. Injury et Work?	28d. Describe how			
	Division	Attending or death.	Certification:	2 Accident investigation 3 Suicida 6 Could not ba determined suicide building, etc. (Specify) 28e. Place of Injury - At home, farm, streat, fectory, office building, etc. (Specify)	28f. Location (Stree	tend Numb	er or Aurel Aou	a Number,
OWENS,	Ö	ital or ins afte al Dire	Cert	4 ☐ Homicide building, etc. (Specify)	City or Town, S	tate)		
DE		To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A complately filled in by the fu	edicai	29a. Certifier (Check only one) 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end place, (Check only one) 2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, death occur and manner state@.	end due to the ceus red at the time, date	e(s) end ma and place,	inner as stated. and due to tha c	ause(s)
		To the Vithin To the	Me	29b. Signature end titla of certifier 29c. Licanse number	29d.	Data signa	d (Month, Dey, 1	(eer)
		5		FUSER 1007 7 D31675	5 F	AUST	2 q,	1998
		yes		Robert Welk = 902 Seton Drive, Cumberla	nd MT) 21	502	
		Sta Regist		31. Dete FEB 1 17, 1998				



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. Amend #7, 2/18/98, EMW, Montg. Co. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** February 16, 1998 VIRGINIA LOUISE POORE 7:55 PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner ring Slivel Spinner Slivel Spinner Slivel Spinner Slivel Spinner Slivel Spinner Spinne Manor Care - Silver Spring Montgomery 5. Social Security Number Birthpiaca (State or Foreign Country) **Funeral** 1□M 2⊠F 578-44-1028 1913 Virginia Director Usual Residence of Decedent death with the Marylend th end Mentel Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examinet must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Prince Georges Directo Ft. Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7501 Fawley Avenue 20744 USA Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Nurse Medical permit. Pages 1 and 2 should be file Department of Health end Mentel Hy, Important: If Item 27 is marked othe any Injury or other traumatic event, base. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Taylor Hynson Dora Pitts 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. informant's Name/Relationship (Type, Print) #6 Alton Point, Berlin, MD Francis L. Poore, Jr. 21811 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1₺ Buriai 2 ☐ Cremetion 3 ☐ Removal from State Fort Lincoln Cemetery 2/19/98 Brentwood, MD 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility Francis J. Collins Funeral 21. Signature of Funeral Sg Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 avent 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel Yrs. emen disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner physician and s the bunal-transit The law requires that the death cartificate be executed Sequentielly ilst conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): 88 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the ceuse of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to should s Completed 24a. Was en eutopsy completion of cause of deeth? certificate hes b 2 0 NO Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA th s 28a. Date of Injury (Month, Dey Year) After thi 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: Naturei 2 Accident or Attending 5 Pending 1 ☐ Yes 2 ☐ No aftar deeth. investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 | Homicide To the Hospital or within 24 hours after To the Funeral Discompletaly filled in 29a. Certifier (Check only one) Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) end manner stated. Medical 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number 043237 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) four Armstruns 1920 Larrel PK Pr

State Registrar

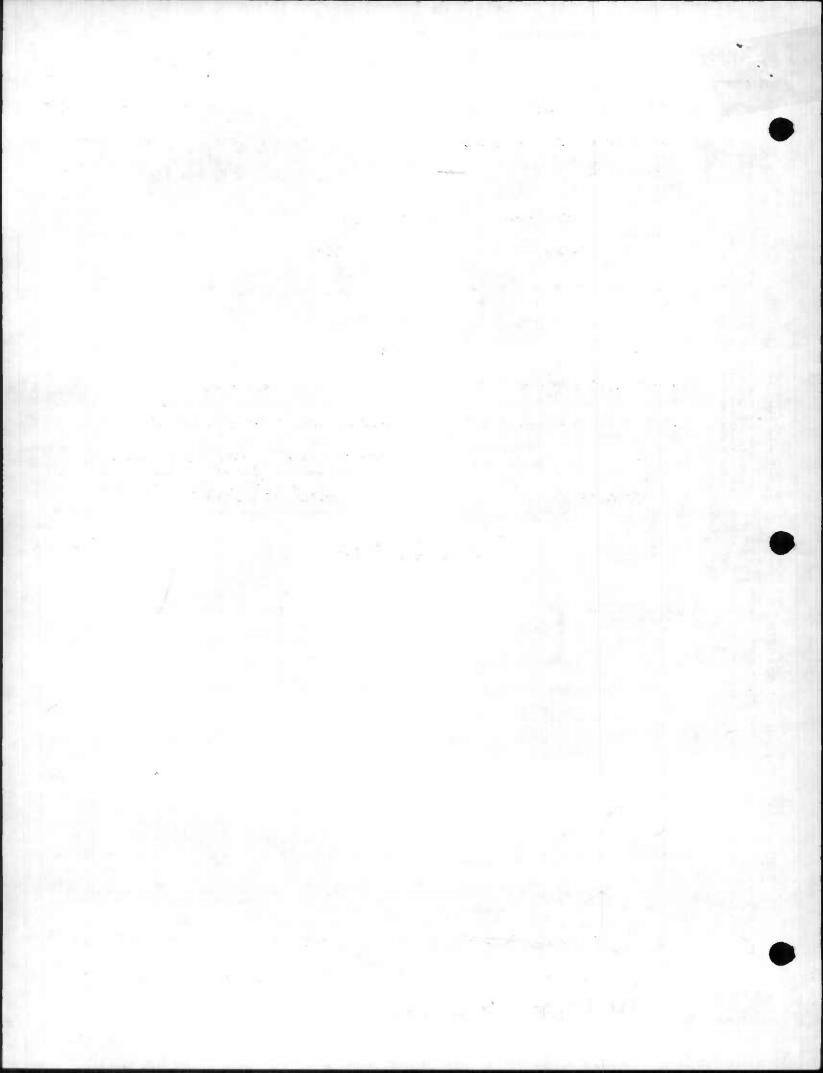
31. Dete filed (Month, Day, Year) FEB 18 1998

Paul Armstrons

32. Registrer's Signature Ashie Davidson

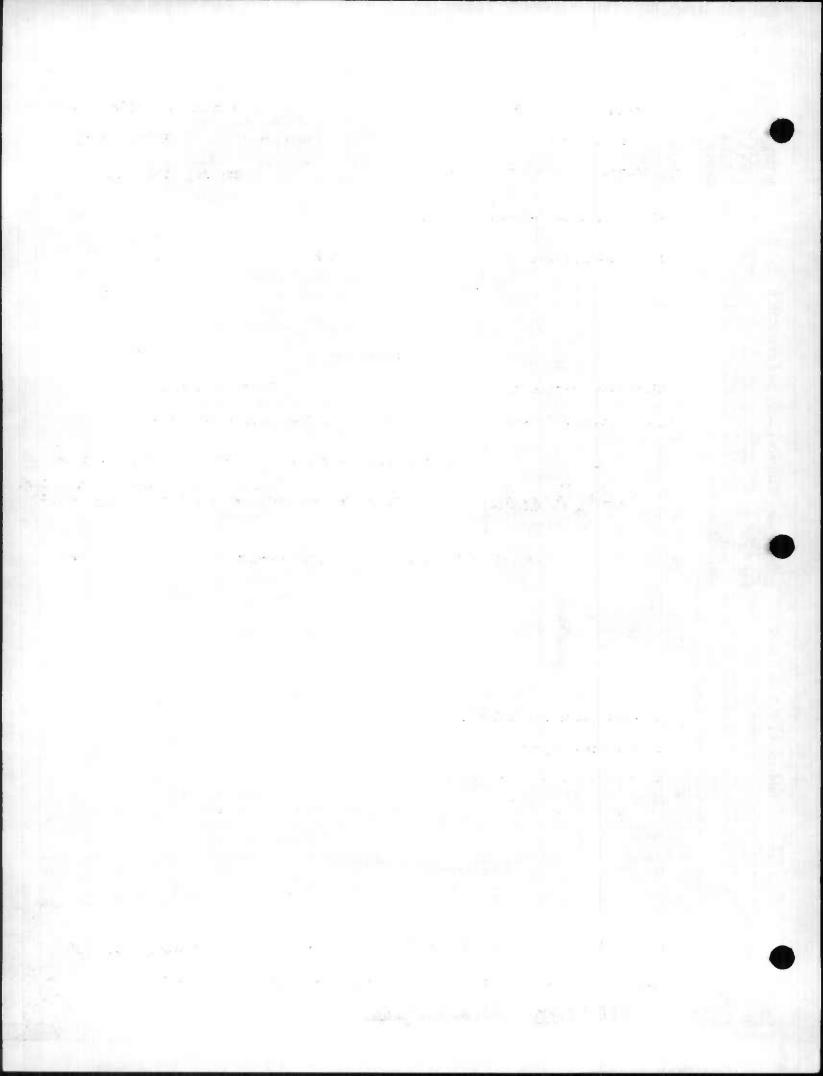
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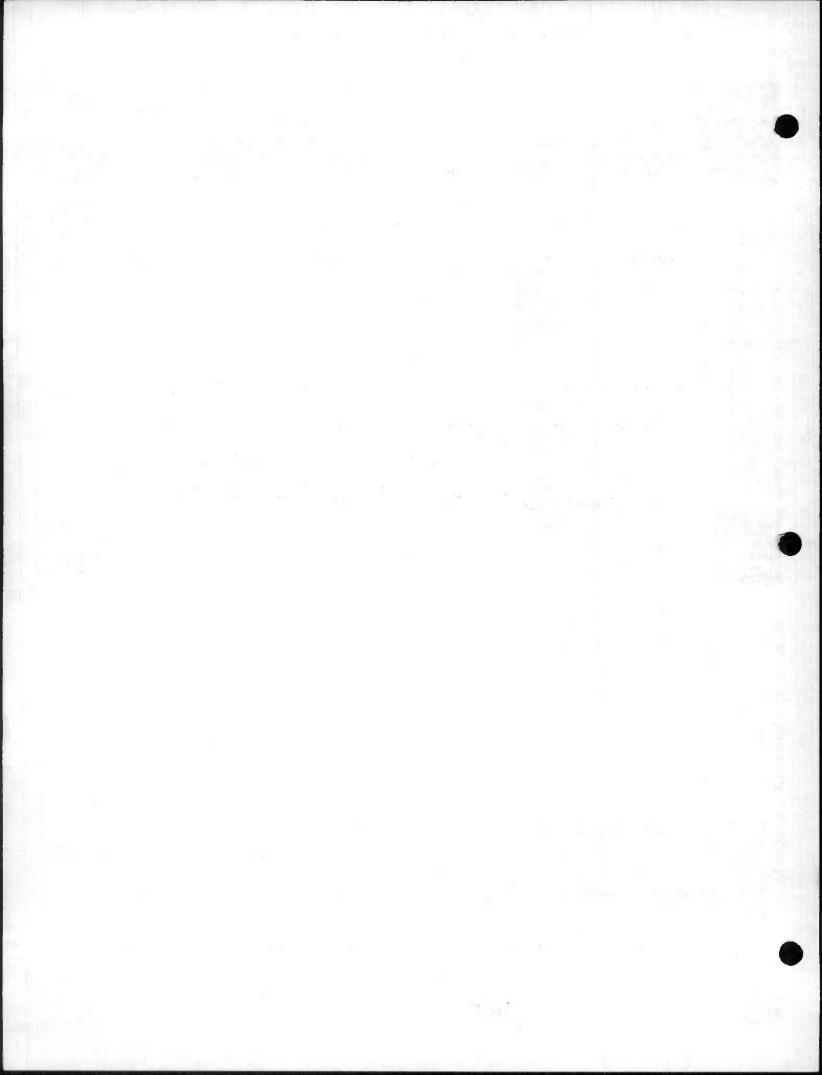
State of Maryland / Department of Health and Mental Hygiene

				Certifica	ate of	Death		Reg. No.	116	866
	1. Decedent's Name (First, Middle, L	ast)					2. Dete of De Month	ath Day	Yeer	3. Time of Deeth
Physician /Medical	Angelina M.	Perluzzi					Februar			11:00 AM
Examiner	4a Facility Neme (If not institution, g)			4b. City, Town, or	Location of Daat	h 4c. County	of Deeth	
	2305 Drexel Str	eet				Hyattsvi	11e	Prin	ce Geo	rges
Funeral Director	577-20-3741	Sex 7. A. 1	ge (In yrs. lest b	Yrs. If Unc Month	s Days		. (Month, De	th by, Year) 1907	9. Birthplac Country Ital	e (Stete or Foreig) Y
pu »	Usuel Residence of Decedent 10a. Steta 10b. County		10c City To	wn or Location					104	. Inside City Limit
ahon ahon		Georges		ttsville					100	1 Ves 2 N
Serie Mark		Georges	Пуа							
th with the 23s or 2	10e. Street and Number 2305 Drexel Stre	eet		10f. 2	Zip Code 207	783		10g. Citizen of V	What Country	?
s within 72 hours after death with the Menyland liene. Then "neturel", or flems 23s or 28s-f show the Medical Examiner must be notified at ompleted by Funeral Director	11. Marital Stetus 1 □ Never Merried 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tes 2 If If Yes, Give Yeer or Dates:	?			Hispanic Origin? (S ben, Mexican, Puer Specify:	Specify Yas or No to Rican, atc.)	Specify	e - Amarican ck, White, etc whi	.
c • # .=	15. Decedent's (Specify only highest g			a. Decedent's Us (Give kind of I life. DO NOT	sual Occu work done use retin	ipation a during most of wo ad)	orking	16b. Kind of Bu	usiness/Indus	itry
filed within Hygiene. Wher than ent, the Me	5	College (1-40)	34)	Seamst	cess			C	lothin	g
ETSE	17. Fether's Neme (First, Middle, Las	t)				18. Mother's Na	me (First, Middle			
ked to o	Giusseppe Piet:	racupa				Ma	ria Vinc	enza		
and Mental Is marked of Mermatic eve	19a. Informant's Neme/Relationship		19	b. Mailing Addre	ss (Stree	at and Number or R	ural Route Numb	er, City or Town,	State, Zip Co	ode)
and 2 selfh a er tree	Anna Falcone / :		71	03 24th	Ave.	Hyattsv	ille MD	20783		
# I I I	20e. Method of Disposition			of Disposition (A ery, cremetory o			Date	20c. Location -	City or Town	, State
amit. Pages epartment of sportant: If the sy injury or o	Donetion 5 Other (Spec			e <i>ry, cr</i> eme <i>tory</i> o Lincoln			2/16/98	Brentwo	od Mar	yland
at the death certificate be executed that by the ettending physician and eteched for use as the burial-trensit and Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last	a severe c	Due to (or es e	e consequence o	of):					years
eth cert ettendin I for use clan/N		d								
dead for sici	Part tt. Other significant conditiona	contributing to death I	out not rasulting	in the undarlying	g cause g	iven in Part I.	23b. Dfd	tobacco use co	ntribute to th	ne cause of deal
res that the de signed by the e I be deteched i I by Physic	1. congestive	heart fail	lure				10	Yes 2 No	3 Probat	bly 4 ☐ Unkno
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ertificate octor, par Be Co	25. Was case referred to medical					26. Place of De	eth (Check only	one)		
O dir	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati	ient 2 ER/C	Outpatient 3	DOA O	ther: 4 Nursing	Home 5 Res	idence 6 Oth	er (Specify)	
ding Phy th. After this funerel of	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident Investigati	28e. Dete of Inj (Month, De	ury ey Year) 28b.	Time of Injury	28c. Inj W	ury et ork?	28d. Describe	how injury occur	red	
tal or Attending P rs after death. al Director: After t ed in by the funer Certification:	2 Accident Investigati 3 Suicida 6 Could not 4 Homlolde determine	be 28e. Placa of In	ijury - At home, tc. (Specify)	farm, street, fact	ory, office	1		(Street end Numb wn, State)	ber or Rurel F	loute Number,
To the Hospital of within 24 hours at To the Funeral D completely filled it Medical Cel		hysictan: To the best miner: On the basis of and mannar s	of examinetion e							
Me Me Me	29b. Signeture end title of central	~	0 00	1	29c. Licer	nse number		29d. Date signe	d (Month, De	y, Year)
0	mora	nmld	AIN	my	D24	593	F	ebruary	13, 1	998
	30. Name and eddress of person who) (Type, Print)				. 1 0070	1	
	Mohammed A. Manna			Terrac	е ну	attsvill	e Maryla	na 20/82	۷	
State	31. Date filed (Month, Day, Year)		rer's Signature	50						



State of Maryland / Department of Health and Mental Hygiene

							(Certificate o		Worker Try	Reg. No.	8 06867
	Discort - 1		1. Decedent's Name	(First, Middle, L	ast)		9 1			2. Date of De		3. Time of Death
	Physici /Medi		Walter	Michael	Pole					Februa	ry 17, 1	998 1:37 PM
	Examir		4a. Facility Name (If	not institution, g	ive street and num	ber)	-		4b. City, Town, or	_		
4			Holy C:	ross Hos	pital				Silver	Spring	Monte	omery
	Funeral		5. Social Security No		Sex 7	. Aga (In yrs	. last birth	iay) if Under 1 Ya	ar If Under 24 Hrs	8. Date of Bir	th	9. Birthplaca (State or Foreign Country)
	Director		185-12-44 Usual Residence of		1₺ M 2□ F	75	Yı	s. Months Day	ys Hours Min	8. Date of Bir (Month, Da July 1	3, 1922	West Virginia
	Pund in		10a. State	10b. County		10c. C	ity, Town	r Location	-			10d. Inside City Limits
	Many Cabo	0	MD	Montgom	0.7477							1 ☐ Yes 2 ₺ No
	28e	ect	10e. Street and Num		lery		2.1.	Lver Sprin			10g. Citizen of V	Affron Country?
	with a	Funeral Director									Tog. CRIZERI OF V	what Country?
	eath mas 23	era	9616 Bris	stol Ave	12. Was Deced	last Ever in I	10		0901	Dana 16 - War and No		ISA .
	Her d	'n	11. Marital Status 1 ☐ Never Marrie	od OF Married	Armed Fore	es?	,,3.	If Yes, specify C	of Hispanic Origin? (S Juban, Maxican, Puar	to Rican, etc.)	Blac	e - Amarican Indian, ck, White, etc.
21215-0020	be filed within 72 hours efter death with the Marylend nal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Exacting must be notified at	Completed by F	3 ☐ Widowed		1 🖾 Yas 2 If Yes, Give Yaar or Da		WWII	1□ Yes 2ĀN	No Specify:		Specify	White .
5-0	72 h natu	etec	(Speci	15. Decedent's E fy only highest g	ducation		16a. D	ecedent's Usuel Occ	cupation ne during most of wo	orkina	16b. Kind of Bu	usiness/industry
21	ithin	nple	Elementary/Secon		College (1~	4or 5+)	1	fe. DO NOT use ref	ired)	iikiiig		
2	w de v	Co	12				Sup	ervisor o	Maintena	ince	Federa	1 Government
nd	al Hy orth	Be (17. Fathar's Nama (i		t)				18. Mother's Na	me (First, Middle,	Maiden Sumam	10)
<u>V</u>	should be filed within and Mental Hygiene. marked other than martic event, the Mental than the Mental than Mental than Mental the Mental than Mental t	L 2	Ustan Par	wluchuk					Anastas	sia Unkno	own	
Maryland	2 should be fight and Mental His marked off		19a. Informent's Na	me/Relationship	(Type, Print)		19b. N	lailing Address (Stre	et and Number or R	urai Route Numbe	er, City or Town,	State, Zip Code)
	Dar.		Alpha Amelia Pole (wife) 9616 Bristol Avenue, Silver Spring, M 20a. Method of Disposition 20b. Placa of Disposition (Name of commatary, crematory or other placa) 20c. Location - City								MD 20901	
Ore	Pege nent of int: If I				7	20b.	Placa of D	isposition (Name of crematory or other a	olaca)	Date	20c. Location -	City or Town, Stata
Ĕ				Cremation 3 I 5 ☐ Other (Spec	□Removal from S ify)		2/18/98	ia, Virginia				
alti.	Departir Departir Importa any Inju		21. Signature of Fur	neral Service Lica	insee	1		22. Name and Add	dress of Facility Fr	ancis J.	Collin	s Funeral
Ö	Ser Se			Kan	94	us li		Home, Inc	. 500 Un		Blvd.	West
	_		23a, Part1 Enter th	a disaasa or co	unlikations that ca	usad the dea	th Do no		oring, MD	20901	rest	Approximate
10	Dhusisian		shock, or hear	t feilure. List onl	one ceuse on ea	ch line.	50110		tying, such as cardia	o or roopilatory at	1001,	Interval Between Onset and Death
0	Physician /Medical		Immediate Ceuse (F	inal		- 61	- 1	1				
1	Examiner		disease or condition resulting in death)		a	951	YSTR	sec.				days
		9				Due to (or as a co	nsequence of):				
	uted Insit	Examiner			b							
_ 10	icete be executed physicien and s the buriel-transit	xa	Sequantially list con if any, leading to Imi cause. Enter Under Cause (Disease or In	ditions, mediate		Due to (or as a co	sequence of):				
9	sicler buri		Cause (Disease or I That Initiated avents	lying njury	C							
68760,	death certificate be executed e attending physiclen and od for use es the buriel-transit	Physician/Medical	resulting In death) L	ast		Dua to (or as a cor	saquanca of):				
	ding ding se es	M			d					_		
Box	eath cer attendin I for use	clar										
o	the de	ysic	Part II. Other signific	cant conditions	contributing to dea	th but not res	sulting in the	ne underlying cause	given In Part I.	23b. Did 1	obacco use cor	ntributa to the causa of death?
Δ.	thet the de ed by the a detached									1 🗆 1	Yes 2□ No	3 Probably 4 Donknown
Records,	lew requires thet the les been signed by the 2 Should be detache	i by								41.77		Odb Wass " "
o	been should	tec									an autopsy med?	24b. Were autopsy findings available prior to
ec	hes b	npidu	***									completion of causa of deeth?
=	The ate	Completed								101	res 2 No	1 ☐ Yes 2 ☐ No
Vital	iclan: The certificate rector, pag	Be	25. Was case referre	ed to medical					26. Place of De	ath (Check only o	ne)	
of	Q 00 Z	2	1 Yes 2	NO	Hospital: 1 ⊒+ff	patient 2	ER/Outp	atient 3 DOA	Other: 4 Nursing I	Home 5 Resid	denca 6 □Oth	er (Specify)
0			27. Manner of Deeth	5 Pending	28a. Dete of	Injury Day Year)	28b. Tin Inju	e of 28c. In	ijury at Vork?	28d. Describe I	now injury occurr	red
0	Attending or death. ector: After by the fune	atic	2 Accident	Investigation	on		,		☐ Yes 2 ☐ No			
Division	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l	288. Place 0	f Injury - At h	oma, farm	, street, factory, offic	се	28f. Location (S City or Tox		er or Rural Route Number,
ō	s efter	Cer			Danding	g, atc. (Opaci	·y/			Only or rov	m, olatoj	
	To the Hospital or A within 24 hours effer To the Funeral Direcompletely filled in b	edical	29a. Certifier (Check only one)	1 Certifying P 2 ☐ Medicat Exa	miner: On the bes	is of examina	wledge, d	eath occurred et the r Investigetion, in m	time, dete and place y opinion, death occu	a, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
	the the	Mec	29b. Signature and t	itle of certifier	and manne	otatet.		29c Line	ense number	- T	29d Date sinner	d (Month, Day, Year)
	F 3 F 8			1 0 /								1
),	11			and C	. Juri	cia		دِهـ	2036+		4/1	7/98
4	7 1		30. Name and addre	ss of person who				pe, Print)	- 0	. 0		(DAVIDGARCIA)
				orres			Rd	Silver	- shird	MU	w710	(DAVIDGARCIA)
	Sta		31. Date filed (Month	n, Day, Year)	32 Re	pistrer's Sign	ature	2.02a	•			
	Registr	ar	FEB	1 9 199	8 guin	Anthridge Anthridge	4					



State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death

Physicia /Medic		Decedant's Nama (First, Middla ELLEN	IRENE		PE	TERSOI	N		2. Data of I Month FEBRI		Day	Year 1998	3. Time of Death
Examin	er	4e. Fecility Nema (If not institution, 2003 WINGATE C						4b. City, Town, or Waldorf				of Death arles	
Funeral Director		579-03-3999	6. Sax 1 ☐ M 2 🛭 F	7. Age (In)	vrs. last birthday) Yrs.	If Under 1 Months	Yaar Deys	Hours Min.	8. Data of E (Month, I OCt.	Birth Day Yes 14,	1915	9. Birthpie Counti Wash	oce (Stata or Foraig 1) 1 ngton DC
ith with the Maryland 23s or 28s-f show	ctor	Usuel Rasidance of Dacedent 10a. State 10b. County Maryland Charle	es	10c.	City, Town or Lo							10	d. Inside City Limite
th with th	al Director	10a. Street end Numbar 2003 Wingate	Court Apt	t. 8		10f. Zip Co		602		10g. (Vhat Count	ry?
tar des items	by Funeral	11. Maritel Stetus 1 Never Married 2 Marrie 3 Widowed 4 Divorcad	Armad F	2⊠ No iva	H	Vas Dacedan Yas, specify		dispanic Origin? (S an, Maxican, Puart Specify:	pecify Yes or to Ricen, atc.)	No-		a - Amarice ck, Whita, e .: Whi	tc.
d 2 should be filed within 72 hours aft th and Mantal Hygiana. 7 is marked other than "natural", or traumatic event, the Medical Example.	Completed	15. Dacedant' (Specify only highest	s Education grada complatad)		16a. Daced	ant's Usual C	Decup dona	petion during most of wor d)	king	16b.	Kind of Bu	usiness/Indu	ustry
be filed within tal Hygiana. Id other than event, tre M	Comp	Elementary/Secondary (0-12)	Collega (1-4or 5+)		Techni				US	Gov	ernme	nt
2 should be filed and Mantal Hygie is marked other is surmatic event, it	To Be	17. Fathar's Nama (First, Middla, L Andrew Peterson						18. Mother's Nan			en Surnam	a)	
nd 2 should alth and Mar 27 is marke r traumatic		19a. Informant's Name/Ralationsh Thomas W. Peter:		n				and Number or Ru Circle, V					Coda)
permit. Pagas 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau 2002.		20a. Mathod of Disposition 1 Surial 2 Crametion 4 Donation 5 Other (Sp.	3 □Ramoval from	State	b. Place of Dispos camatary, cran rinity M	etory or othe	r pla	Gardens	Data 2-23-98			City or Tow	m, Stata
permit. Departr importa any inju		21. Signature Funaral Sarvice L Mark G. Br	ohawn MC	00053	✓ H	untt F	un	eral Home			20604	-0156	
Physician /Medical		23a. Part1. Enter tha diseese, or of shock, or haart failura. List o	complications that only one couse on	caused the deach line.	1								Approximate nterval Between Onset and Death
Examiner		Immediata Cause (Finel diseasa or condition rasulting in daath)	a	Mus to	clevoluc o (or as a consequence	Care	lo	vaoculon	dise	rse		-	
nsit	Examiner		. b. N	ryoc	ordist	m	fo	nd				_	
be axecuted siclan and bunal-transit		Sequantially list conditions, if eny, laading to immadiata ceusa. Entar Undarlying Causa (Disease or Injury		My	pertint	ence of):	V						
ath cartificata be axecuted ttending physician and or usa as the bunal-transi	an/Medical	that initiated evants rasulting in death) Last	d	Duelte	(or as a consequ	ence of):							
d by the a	Physici	Part II. Other significant condition	e contributing to d	eath but not r	resulting In tha un	darlying caus	sa giv	ran In Part I.			co use cor	/	the cause of death
a law requiras that has been signed b ga 2 should be date	Completed by								24a. We per	s an eu formed?	topsy	com	a autopsy findings lebla prior to pletion of ceuse aath?
iletan: Tha law requiras ti cartificata has been signe rector, paga 2 should be o		W							10] Yes	2 X No	10	Yes 2□ No
yslcian: s cartific director	o Be	25. Was cesa referred to medicel axaminar? 1 Yes 2 No	Hospital:	Inpatiant 2	□ ER/Outpatient	3∏ DOA	Oth	26. Place of Dea			6 □Oth	er (Speciful	

To the Hospital or Attending Physicities within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. Medical Certification:

27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Panding invastigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 🗌 Suicida Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homleide 29a. Cartifiar

1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

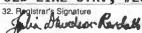
29b. Signatura and titla of certifiar 29c. Licanse number 29d. Dete signed (Month, Day, Yaar)

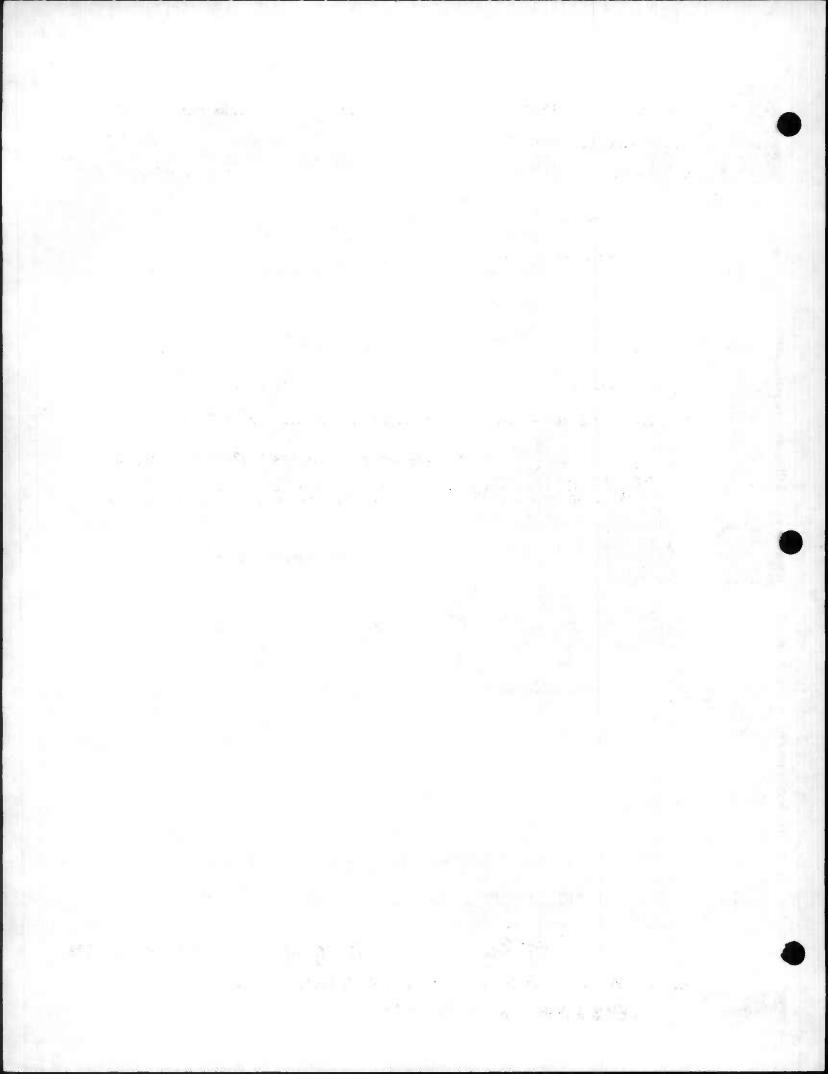
FEBRUARY 18, 1998

30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

R. TIMOTHY PACE, 700 OLD LINE CTR., #202, WALDORF, MD 20602

State Registrar 31. Data filad (Month, Day, Year) FEB 2 3 1998





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** ESTELLE **PAULS** LULA BRICKHOUSE FEB 12 1998 3:35AM /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL @ EASTON TALBOT EASTON If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) Hours 1 M 2 TF 220-03-5265 Yrs. FEB.22,1922 EXMORE, VA. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 □Xes 2 □ No Director MD. QUEEN ANNE GRASONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 107 GRAVEL RUN RD. 21638 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 □ Never Merried 2 □ Married 1 ☐ Yes 2X No Specify: þ Specify: BLACK 3X Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 09 SALES RETAIL 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN WILLIAM BRICKHOUSE MARY LECATO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ROBERT L. LOPEZ-LAYTON 3500 COPLEY RD. BALTIMORE, MD. 21215 20b. Placa of Disposition (Name of cemetery, cremetory or other place)
ROBINSON CHURCH CEME. 20a. Method of Disposition Date 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 2/18/98 GRASONVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DASHIELL FUNERAL SERVICES 319 E. DOVER ST. EASTON, MD. 21601 23a. Part 1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth Congestive Heart for lure

Due to (or as a consequence of):

Chronic Renal for lure Immediate Cause (Final 10 years disease or condition resulting In death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pertension Physician/Medicai Due to (or as e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Munknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending 1 Naturel 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide THE Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) D00511 2/12/98

332 N. MAIN STREET

32. Registrar's Signature

FEDERALDSBURG, MD. 21632

State Registrar

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

JORGE ABREGO M.D.

FEB 1 8 1998

31. Date filed (Month, Dey, Yeer)

Funeral

Director

re 23a or 28a-f show

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injury or other traumatic event, the Medical Examiner

marked other than

Depertment of Health ar Important: If Item 27 is any injury or other trau

Physician

/Medical

Examiner

end

cate hes been signed by t page 2 should be detech

this certificate

After

death.

ofter death

24 hours Hospital

within 2

in by

The law requires that the death certificate be executed

P.O. Box 68760,

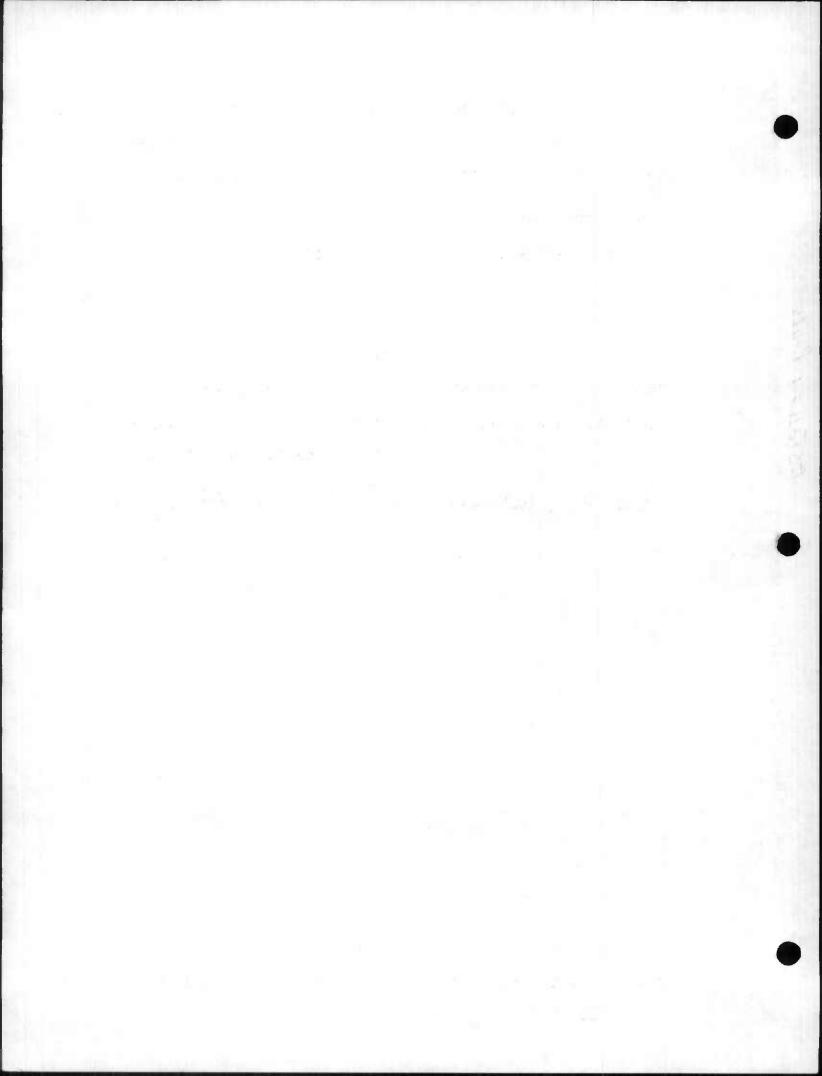
Division of Vital Records,

or Attending Physician:

Hygiene.

Pages 1 end 2 should be finent of Health and Mental I inter 27 is marked of

the Maryland



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath **Physician** Month Day 0900 Febra ary
4b. City, Town, or Location of Death RUTH EMMA VAN PELT /Medical 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** WASHINGTON HAGERSTOWN WASHINGTON COUNTY HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Dey, Year) | Min. | MAR | 13 | 1922 5. Sociel Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** 1□M 2□E PENNSYLVANIA Yrs. Director 75 217-28-7409 Usuai Rasidance of Dacedant the Merylend 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits item 27 is marked other than "nature!", or items 23s or 28s-f show other traumatic event, the Madical Examinat must be notified at 1 Yas 2 No Director RD 1 BREEZEWOOD PENNA BEDFORD 10e. Street and Number 10f. Zip Code 10g Citizan of What Country? USA 15533 RD 1 BOX 167 deeth Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritai Status 72 hours efter 1 ☐ Yas 2 💢 No if Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No WHITE Specify: by 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: If than 27 is marked other than "n any Injury or other traumath. Elementary/Secondary (0-12) Coilaga (1-4or 5+) OWN HOME 12TH HOMEMAKER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maldan Sumama) Be FRANK DEREMER ADA WILLIAMS 10 19a. informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) RD 1 BOX 167, BREEZEWOOD, PA, 15533 ROBERT VAN PELT/HUSBANd 20c. Location - City or Town, Stata 199820a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or othar placa) FEB 12 X Buriai 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) MT. PLEASANT LUTHERAN CEMETERY E. PROVIDENCE TWP PA 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility DALLA VALLE FUNERAL SVC INC PO BOX 179 EVERETT, PA, 15537

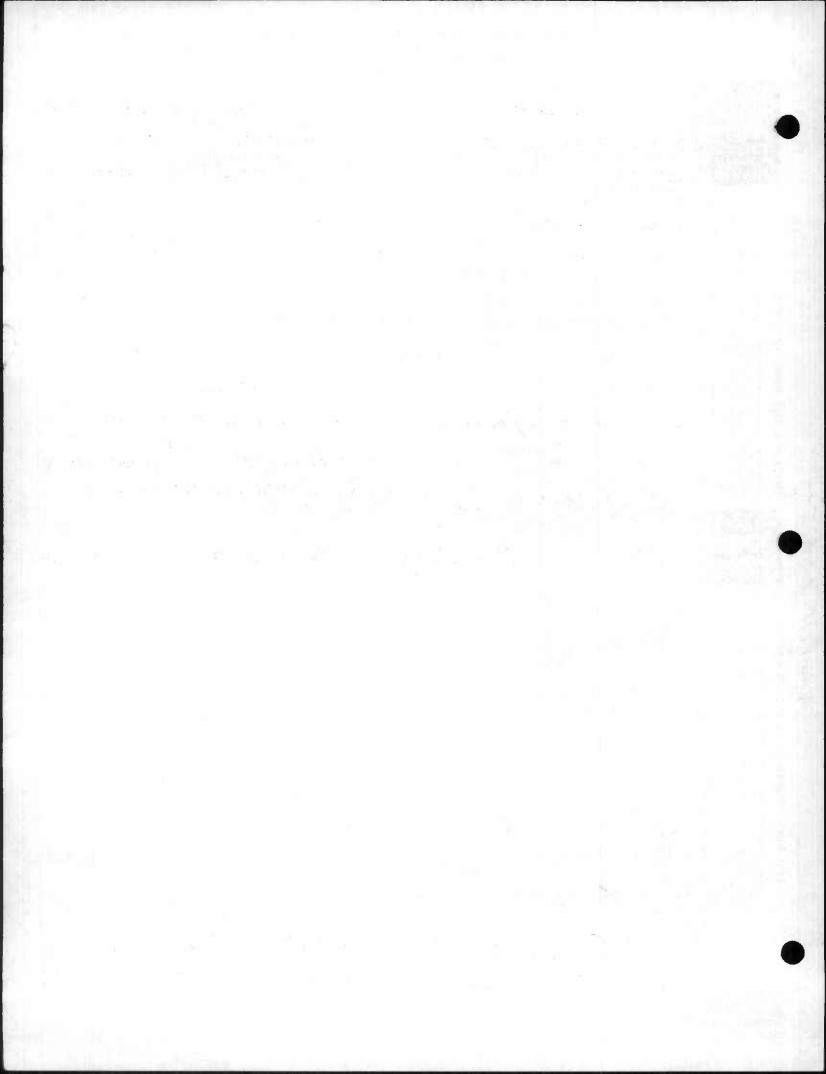
EVERETT, PA, 15537

EVERETT, PA, 15537

Block of heart feiture. List only one ceusa on aach line. Approximata Intervei Between Onsat and Death **Physician** Calcinoma /Medical immediata Causa (Final disaasa or condition resulting in daath) Bronchogenic Months Examiner Dua to (or as a consaquance of): buriel-transit Sequantially list conditions, if any, laading to immediata cause. Enter Undarlying Causa (Disaase or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) ettending physician for use es the burie Physician/Medical Dua to (or as a consequence of) signed by the e Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ρ 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy Completed Deed certificate 1 Yas 25 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only ona) 1 Yas 2 No Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidenca 6 ☐ Othar (Specify) Certification: To inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Deeth 28c. injury at Work? 28d. Describe how injury occurred 28h Tima of 28a. Date of injury (Month, Day Year) 1 Maturei 5 Panding 1 ☐ Yas 2 ☐ No 2 Accidant invastigation 6 Could not be datamined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, streat, factory, offica building, atc. (Specify) 4 Homicida Certifying Physician: To tha best of my knowledge, death occurred et tha time, date and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. 29a. Cartifier Medical (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 1 4 OAKHILL AVE HAGER STOWN. 30. Name end eddress of person who completed causa of daath (Item 23a) (Type, Print) VAHEED WD 2821 1263 Boul 31. Data filed (Month, Day, Year) 3. Registrar's Signature State FEB12 Registrar

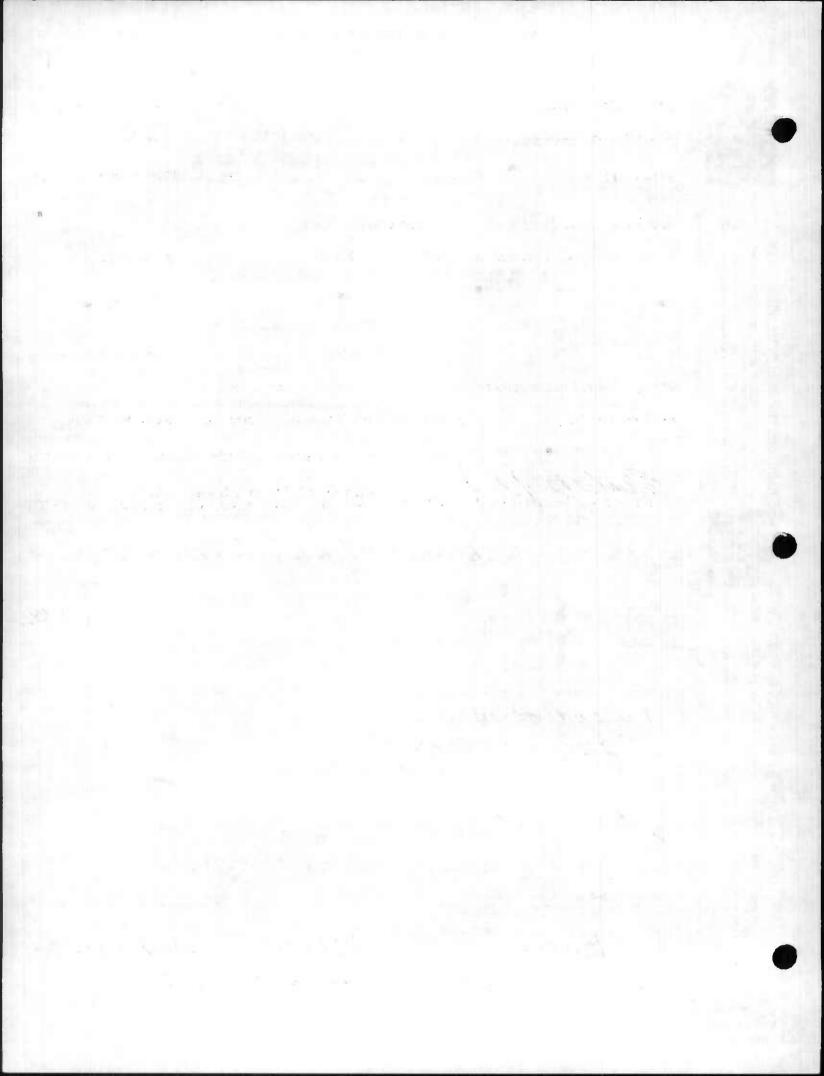


State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** February 25, 1998 Mary Alice Ouinlan 1:22 PM /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 5. Social Sacurity Number If Undar 1 Yaar if Undar 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** 1□ M 2■ F Months Days Hours Yrs. Director May 30, 1925 North Carolina 241-30-1250 Usual Rasidanca of Dacedani with the Merylenc show 10a State 10h Counts 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Medical Experiment must be notified at 1 ☐ Yas 2 ■ No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 22680 Cedar Lane Court, Apt. 1215 20650 United States Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ■ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 □ Navar Married 2 □ Married Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) Operator Telephone Company 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Pages 1 and 2 should be 1 tent of Heelth and Mental I nt: If Item 27 Is marked of George Cleveland Winstead Carrie Mae Cobb 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Wesley Quinlan, 48152 Peachtree Way, Lexington Park, MD 20653 Son other Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ■ Ramovai from Stata Department of Important: If any Injury or Injury or Cedar Grove Cemetery 3/2/98 Elm City, North Carolina 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Brinsfield Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast,

Approximate

Approximate Approximata Intarval Batween Onsat and Death **Physician** CHIONIC OSSENCIAVE GIVE /Medical Immediata Causa (Final disaasa or condition resulting in death) Examiner Examiner physician end the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that Initiated events resulting in death) Last Dua to (or as a consequance of): x 2 4/15 Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquence of): 80 ed by the e Part II. Other algnificant conditions contributing to death busnot rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Depression py 2. gastroesophered 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? complation of causa of daath? has 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital director 25. Wes case referred to medical axaminar? Be 26. Placa of Death (Check only one) To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2€No this funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Time of Certification: 28c. Injury at Work? 5 Panding invastigation 1 Natural offer death. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be daterminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 Homicide Hospital 24 hours e 24 hours edical 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to tha causa(s) end mennar as stated.

/ 2 Medicaf Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) 29e. Certifier compietely (Check only one) and mannar stated. To the To the To the I 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number 10mls 30. Nama and addrass of person who completed cause of deeth (Item 23a) (Type, Print) Hollywood MD mehts. 31. Data filad (Month, Day, Year) 32. Registrar's Signatura State Julia Davelson Randall FEB 27 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month Charlotte D. Ruffo **FEBRUARY 20 1998** /Medical 10:45 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Sacred Heart Hospital Cumberland
If Under 24 Hrs. 8.
Hours Min. 8. Allegany if Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Deys 1 ☐ M 2 🖸 F Yrs. Director 216-18-1245 Mar 24, 1921 MD Usuel Residenca of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1√2 Yes 2 No Director Allegany Frostburg 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 100 Honeysuckle Lane 21532 Funeral USA r than "natural", or items the Western Examiner on 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 21215-0020 þ 1 Yes 2X No Specify: 3 Widowed 4 □ Divorced Specify white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the West Elementery/Secondery (0-12) College (1-4or 5+) Tavern 12 Owner and Operator altimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Pages 1 and 2 should be 1 nent of Health end Mental I ant: If Item 27 is marked or Walter Duncan Emma (Meagher) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) nt of Health e If item 27 is or other tra Carl H. Ruffo-husband 100 Honeysuckle Lane Frostburg MD 21532 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State permit. Page Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Michael's Cemetery 02/22 Frostburg MD 21. Signeture of Funerel Service Licensee 22. Neme end Address of Facility Scarpelli Funeral Home, P.A. Cumberland MD 21502 23a. Pert / Enter the disease, or complications thet caused he disease, or heer failure. List only one ceuse on each th. Donot enter the mode of dying, such es cardiac or respiretory errest, Approximete intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final Low dus disease or condition resulting in death) Examiner 145 The law requires that the death certificate be executed the buriel-transit Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequença of) P.O. Box 68760, Physician/Medical Due to (or es e consequence of): for use es Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? Atial Librilation 1 Yes 2 No 3 Probably 4 Unknown Records, 8 24b. Were eutopsy findings eveilable prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? this certificate 1□ Yes PNo 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: within 24 hours after death.

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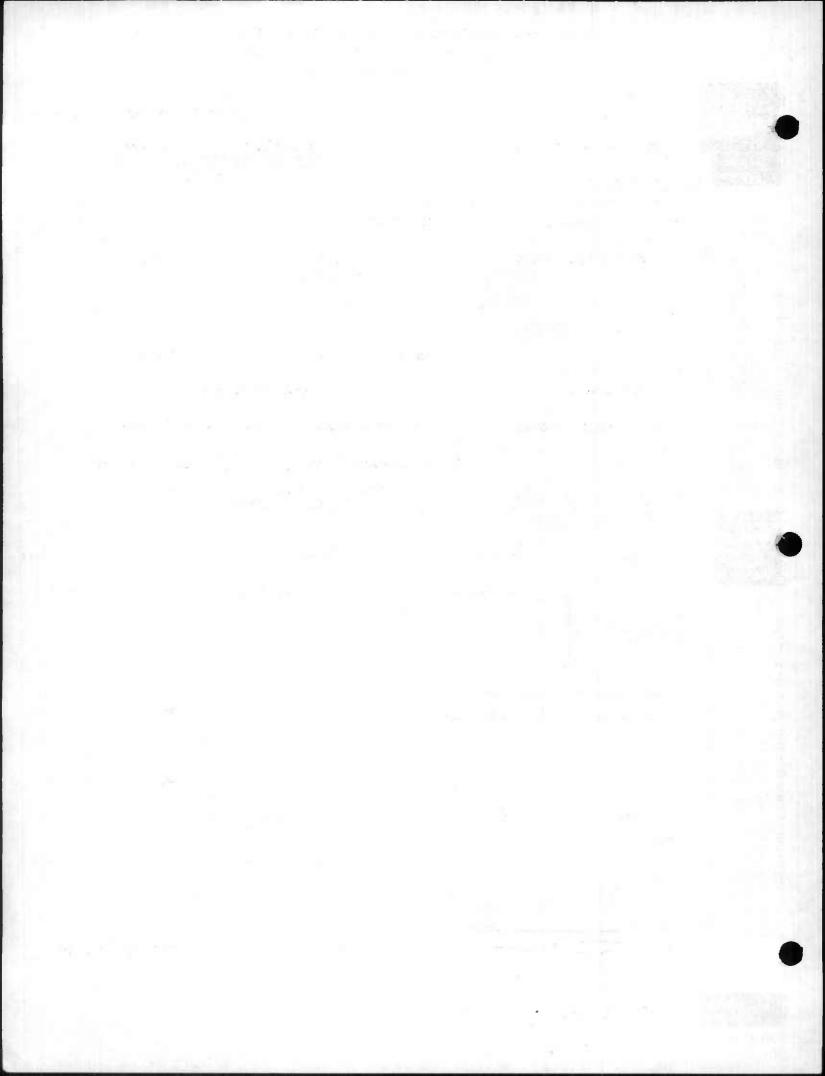
2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) end menner steted. 29a, Certifier Medical 29c. License number 29b. Signature end title of certifier. 29d. Dete signed (Month, Dev. Year) FEBRUARY 23 1998 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 909 B Seton Drive Cumberland HD 21502

726 State

Registrar

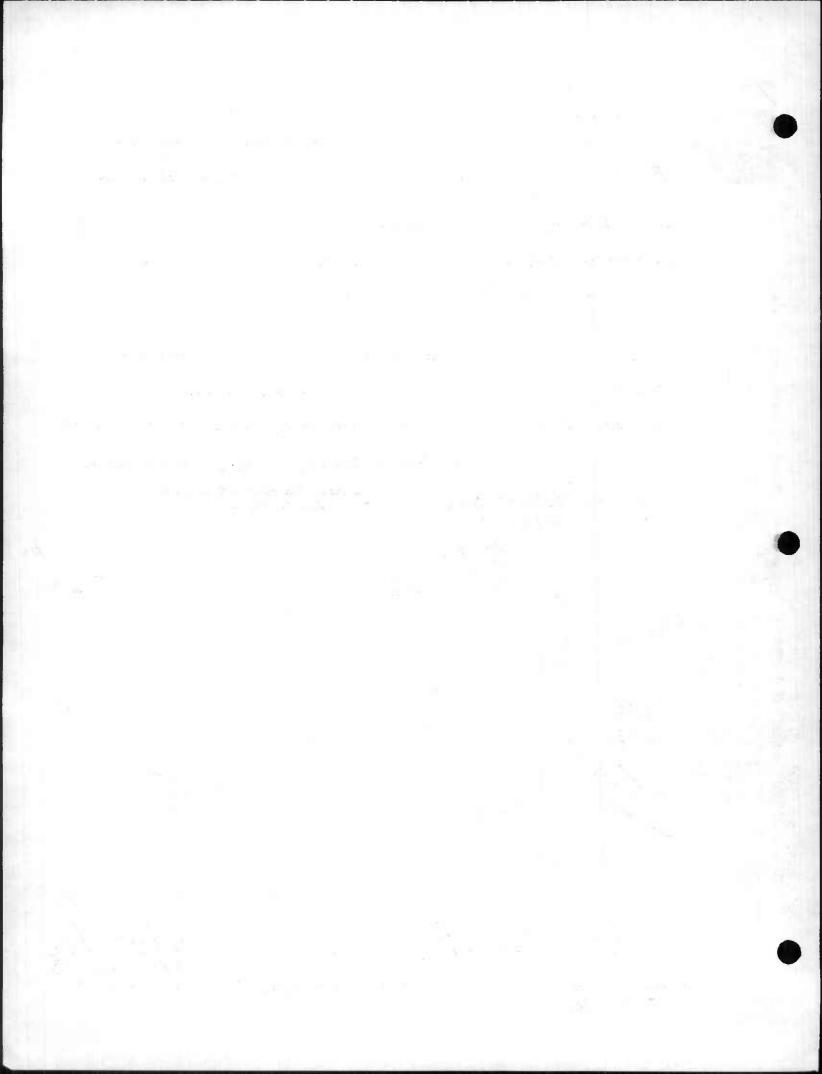
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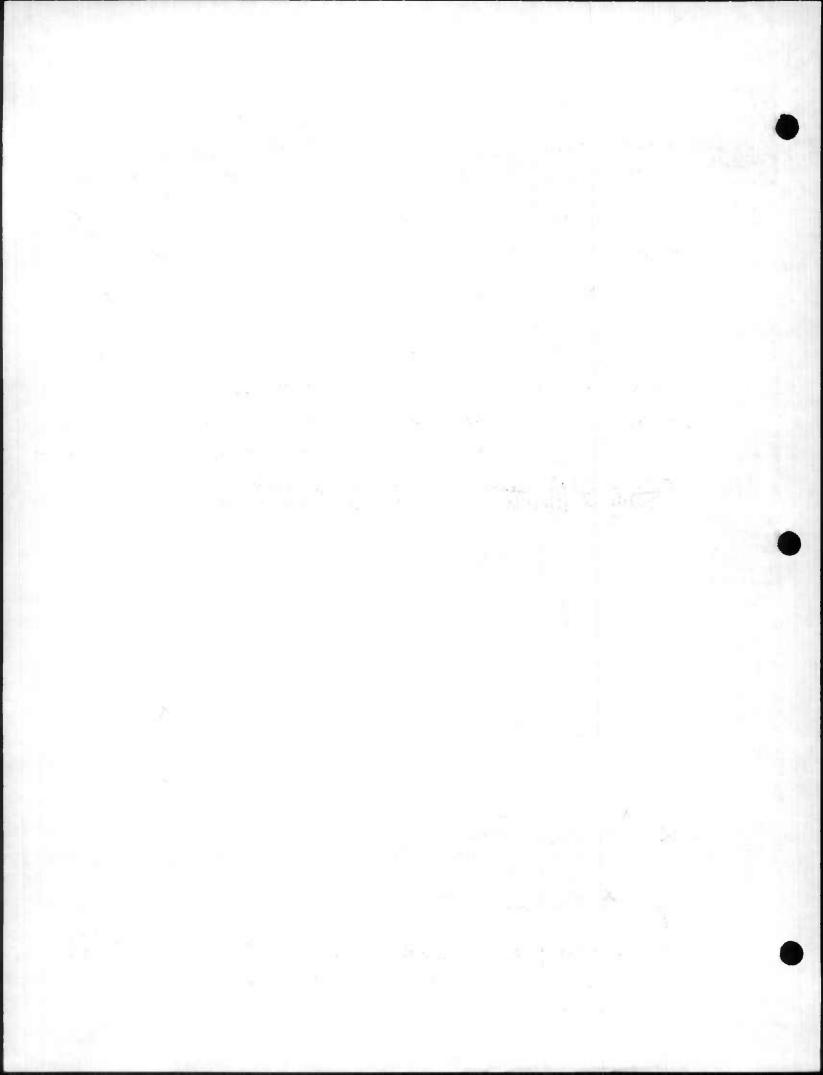


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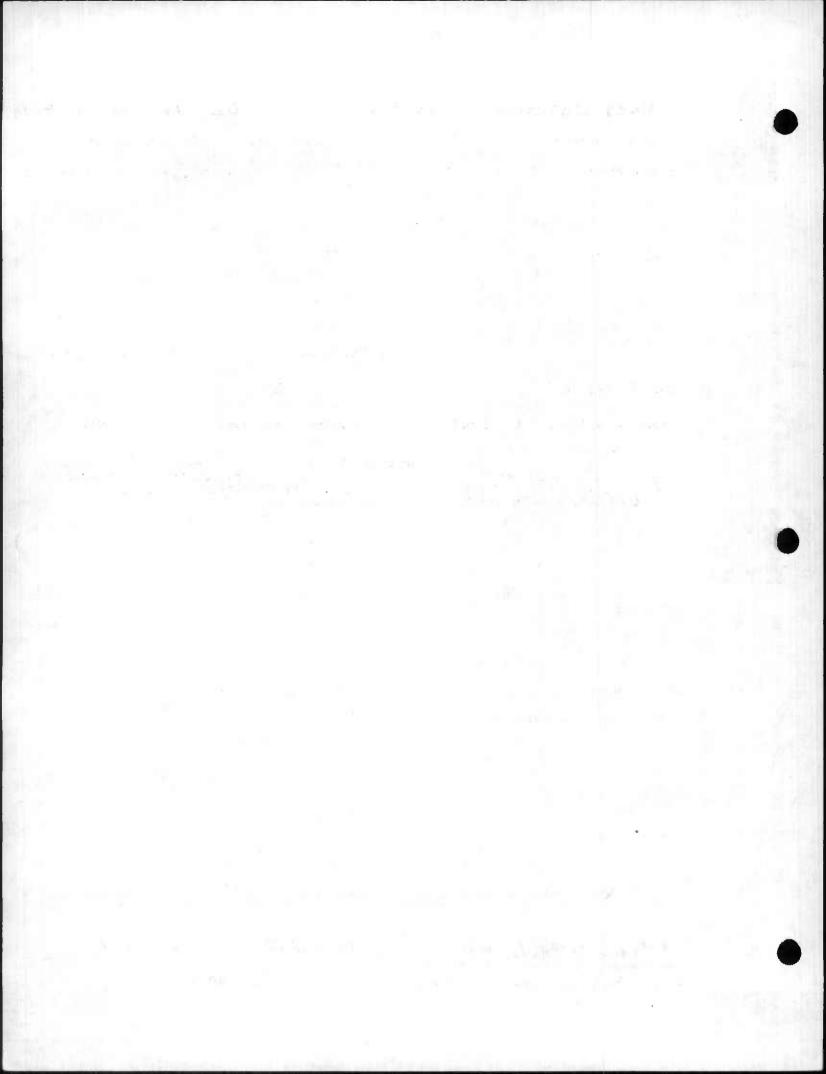


					- Iviai yiai		ificate of	Death		Reg. No.	00	0/4
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/Med	lical	4a. Facility Name (//			nher)			4b. City, Town, or	FEBRUAI			1:05 AM
Exam Funera Directo	1		HOSPITA	Ц	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Deys	CUMBERLAN	D_	ALLF	EGANY	(State or Foreign
pue »		Usual Residence of 10a, State	Decedent 10b, County		10c Ci	ty, Town or Loca	etion					Inside City Limits
Aaryle f sho	5	MARYLAND	ALLEGAN	īV		UMBERLA!						1 Yes 2 No
the 28a	Director	10e. Street and Nur			0	OIID LICEIN	10f. Zip Code			10g. Citizen of	What Country?)
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72 hours efter deeth with the Maryland *naturel", or Itama 23a or 28a-f show idical Exampler must be notified at	by Funeral	11. Marital Status 1 □ Never Marri 3 □ Widowed	2.1	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	ces? 2 [XNo e	lf Y	as Decedent of logs, specify Cub	Hispenic Origin? (S pan, Mexican, Puerl Specify:	Specify Yes or No to Rican, etc.)		ce - American lock, White, etc.	
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permit. Pege Depertment of Important: If any injury or		21. Signature of Full	neral Service Line	osult		ME		ess of Facility DAMS FUNE UR STREET			OVI AND	
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es that the igned by be detected									1 🗆	Yes 2 No	3 Probabi	ly 4 Unknown
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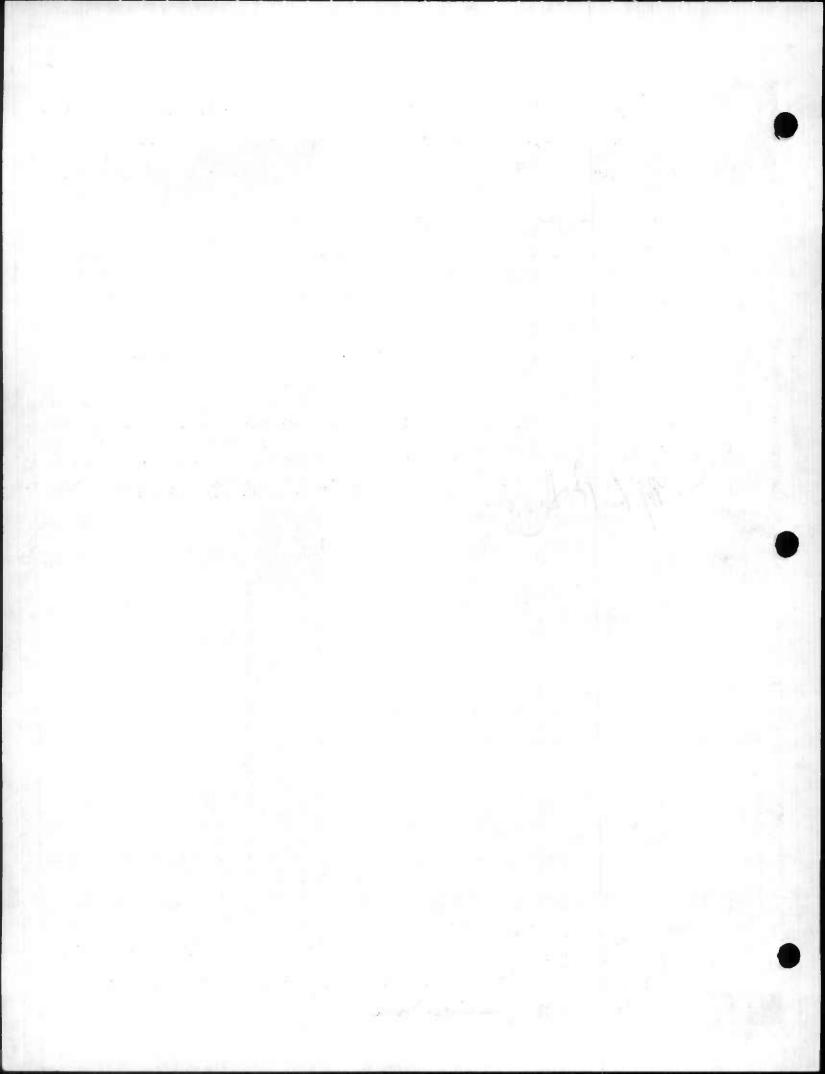
					Certi	ificate o	f Death		Reg. No.	0 0	010
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by Br.	2	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:		1	Yes 2⊠N	o Specify:		Specif	y: Wh	nite
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event, the M			2	34)	Purcha	sing A	gent		Federal	Gove	rnment
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		John Fischbach					Kather	ine Gra	f		
E		19e. Informent's Neme/Reletionsh	(Type, Print)		19b. Meiling	Address (Stre	et end Number or Ru	ral Route Numb	er, City or Town	, Stete, Zip	Code)
or tre		Frank E. Wilson	i, III (s	on)	4429 4	9th St	reet, NW,	Washin	gton, DO	200)16
oth	2	20a. Method of Disposition		20b. Ple	ece of Dispositi		Jaca)	Dete	20c. Location		wn, State
any Injury or other tra		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spe			ropolit			2/16/98	Aloxandr	ria T	Virginia
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any in		DI IMMANI	01'1		Hom	e, Inc	. 500 Un:	iversity	y Blvd.	West	
	+	23a Pert1 Enter the disease or o	moliculions that caused	the death	Do not enter	ver Sp		20901	rroot		Approximete
lolon		23a. Pert1. Enter the disease, or c shock, or heart failure. List or	ly one sause on each li	ne.	. Do not ontor	ino mode or d	ying, addit os cardiac	or respiretory e	most,		Intervel Between Onset and Death
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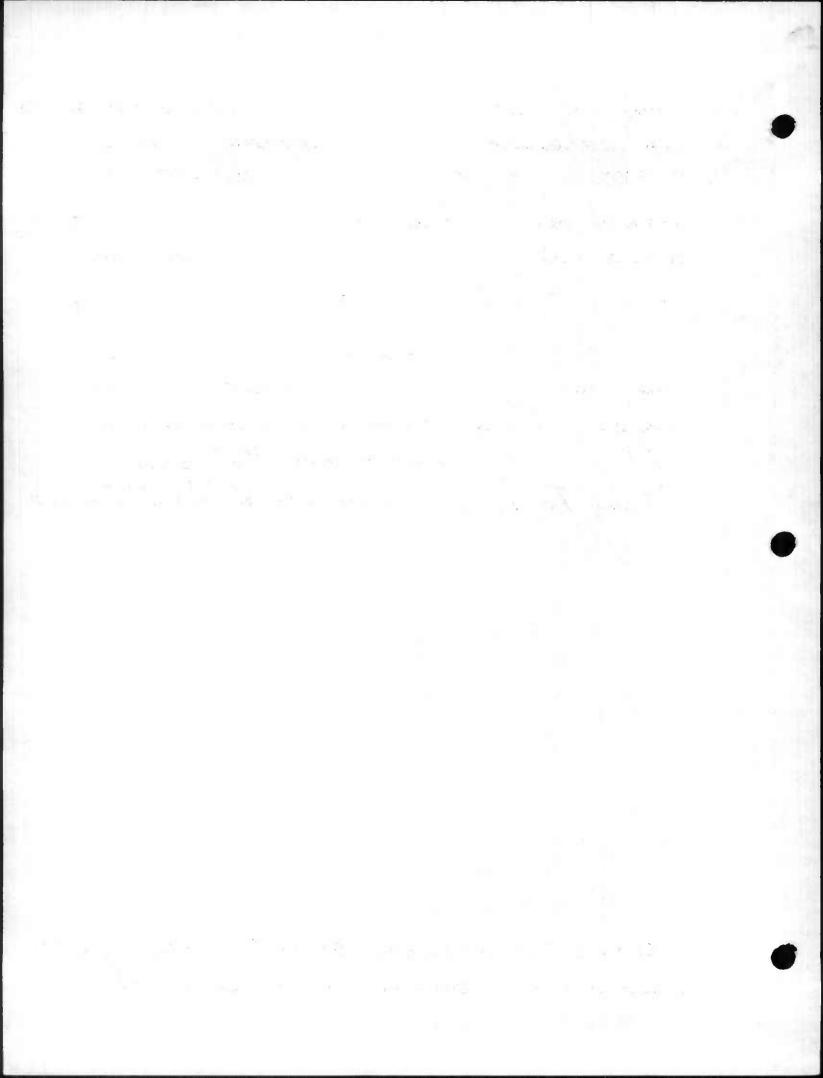
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Т	Funeral	Г	5. Sociel Security Number 6. S	ex 7. Age	e (In yrs. lest bir	thdey) II U	nder 1 Year ths Days	If Under 2		B. Date of Birt (Month, De		ч	plece (State or I	Foreign
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	pu ,		Usuel Residence of Decedent											
	aryla ahov	_	10a. Stete 10b. County		10c. City, Tow	n or Location						1	10d. Inside City	
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	# 20 K	Director	10e. Street end Number			10f	. Zip Code				10g. Citizen of	Whet Cour	ntry?	
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<u>\$</u>	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ertification:	3 Suicide 6 Could not be determined	28e. Pleca of Injurbuilding, etc.	ry - At home, fer	m, street, fac	tory, offica		28	Location (S City or Tow		ber or Rura	al Route Numbe	HE,
	al Di	Cer		Dononig, oto.	(Opouny)					Only or You	n, ototo,			
	To the Hospital within 24 hours To the Funeral completely filled		29e. Certifier 1 Certifying Phy	reician: To the best of	my knowledge,	deeth occur	red at the tin	ne, date end	pleca, end	due to the c	euse(s) end m	enner es si	teted.	
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			30. Name and address of person who o	ompleted gause of de			-	2 .		11			1. 110	
			D. D. PATEL, M	9. 6121	MONTO	SOJE	RD, 1	Se uk	vil	le, L	19 20	78 c	7,1998	
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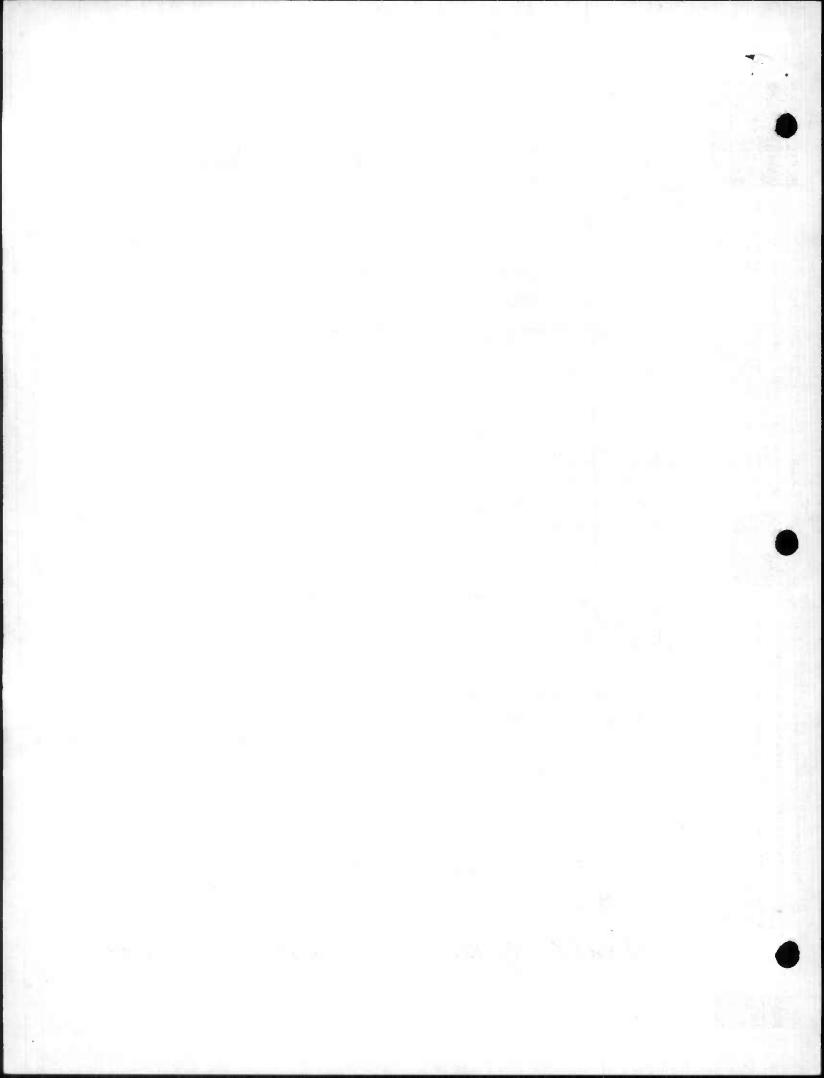
State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificat	e of	Death			Reg. No.	98	0 (687	17
	Physic	ian	1. Decedent's Nama (First, Middle,	Last)							2. Dete of D Month	eath Dey	Y	eer eer	3. Time	of Death
	/Medi		HELEN B.	RYNER							FEBRUA	RY 19			11:	50 AM
<i>)</i>	Exami	ner	4a. Fecility Name (If not institution,	give street and number,)				4b. City, To	wn, or Lo	cation of Dea	th 4c. C	county of	Death		
			WILSON HEALTH CA				Milladas	1 W- 1-	GAITE				NTGO			
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	hend the		10a. Stete 10b. County		10c. City	, Town or Lo	ocation							10	d. inside	City Limits
	72 hours after deeth with the Meryland natural, or items 23s or 28s-f show deal Examiner must be notified at	tor	Maryland Montgo	merv	Ga	ithers	hurg								1 🙀 Ye	s 2 No
	or 284	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	en of Wha	at Count	ry?	
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saltimore,	E 6 3		21. Signature of Funeral Service Lie		XIC.				ass of Facilit	V -	998	Alex	-		VA	
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	/Medical Examiner be executed by sicial end street privately street by the private stree	Examiner	Immediete Cause (Final disease or condition rasulting in deeth) Sequentially list conditions, if eny, leeding to immediete causa. Enter Undarlying Cause (Disease or Injury	· Upg	universitä	r as a consec	prenoe or):	rā	tor	y.	ing	ect	toi	e "	One	ek
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<u>Ö</u>	Attending at death. ector: After by the fune	atic	2 Accidant investiget	ion	, ,	,,	M		Yes 2	No						
Division	bei or Attending Pris ofter death. al Director: After tied in by the funera	Certification:	3 Suicide 6 Could not determine		jury - At ho ic. (Specify	me, lerm, str	eet, lectory	, office		2	28f. Location City or To	(Street end own, Stete)	Number	or Rural	Route Nu	mber,
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State of Maryland / Department of Health and Mental Hygiene

December 19 Manual Properties December 19 Manual Propertie							Certi	ificate of	Death	,	Reg. N	. 98	U	6878
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Suburban Hospital Financial Suburban Hospital Social So		•		Ilona Ve	rtesy Re	ynolds					11,	1998	raei	1:12 PM
Social So				4a. Facility Nama (If not Institution	give street and number)			4b. City, Town, or L	ocation of Deat	h 4	c. County o	of Death	
Social So				Suburban Hosp	ital				Bethesd	а		Mont	tgome	rv
Usual Residuation of Decederal Values of the State of The	_	Funeral		5. Social Security Number		ga (In yrs. last bi			if Undar 24 Hrs.		th	,		
The State 100 County 100 City from recording 100 Zep Code 100 Citisen of What County 100 Citi	E				1□ M 2□7F	82	Yrs.	vionins Days	Hours Min,	Dec.2,	1915	5 1	Hunga	ry
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State of Maryland / Department of Health and Mental Hygiene 98 06879

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		Susan B. Robe	erts - Nh	Dian-	J Nau	SI Mr	tical (ontor	Bethrad-

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 15, 1998 February 4b. City, Town, or Location of Death 4c. County of Death 01ney Montgomery 8. Dete of Birth (Month, Day, Year) Feb. 12, 18 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 M 2 F Yrs. 1899 99

Funeral Director the Maryland r 28a-f show a notified at Pages 1 and 2 should be filed within 72 hours effer deeth with 1 and distance of Health end Mentel Hygiene. r than "natural", or items 23a or the Medical Examiner must be Baltimore, Maryland 21215-0020 **=** 8 Department of mportant: If

Physician /weahear Examiner physician end s the buriel-trensit that the deeth certificate be executed P.O. Box 68760, 80 950 signed t Division of Vital Records, peen certificate has b lirector, page 2 s this funeral or Attending Patter deeth.

Director: After 1 After To the Hospital or Attervithin 24 hours efter decorpt to the Funeral Director completely filled in by the

Examine Physician/Medical þ Completed Be Certification:

27. Manner of Death 1 Neturel 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide 29a. Certifier edical (Check only one) 29b. Signatu 31. Date filed (Month, Dey, Year) State

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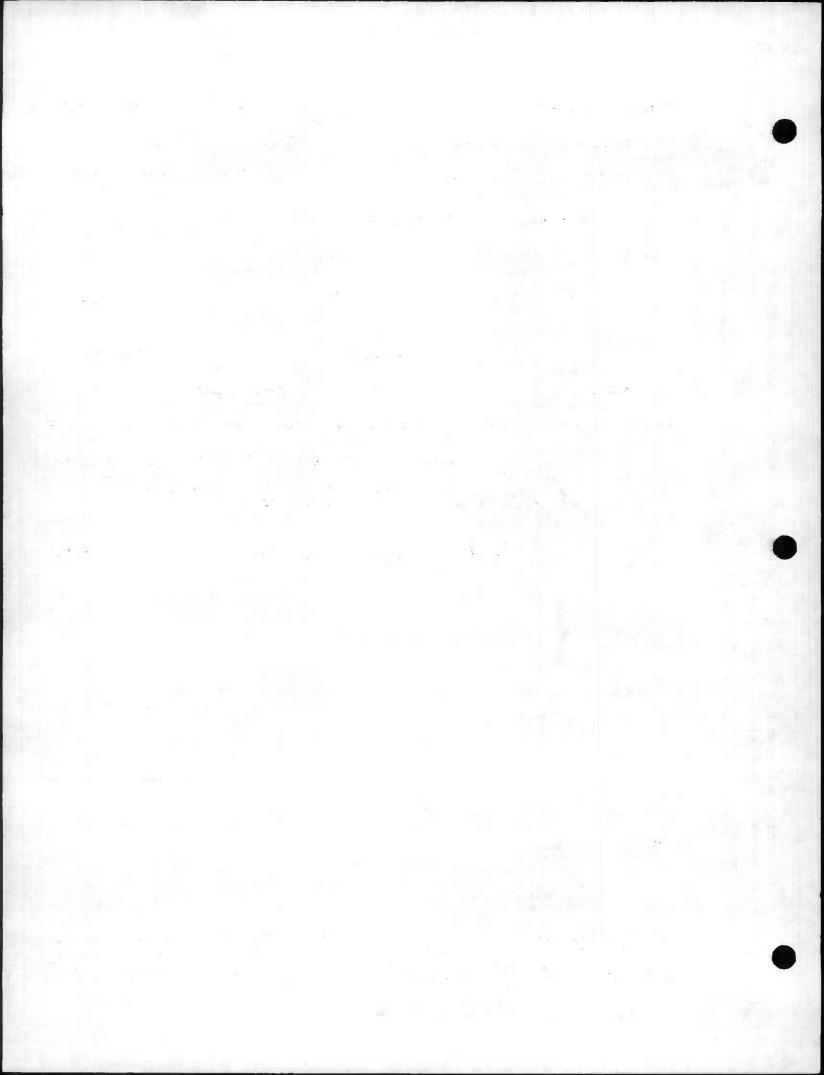
Physician Margaret G. Reese 1:58 PM /Medical 4a Fecility Name (If not institution, give street end number) Examiner Montgomery General Hospital 5. Social Security Number Birthplace (State or Foreign Country) Washington, DC 578-09-2878 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3398 Glen Eagles Drive 20906 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 ☐ Never Married 2 ☐ Merrled 1 Yes 2 No Specify: Specify: White þ 3 ™ Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Manager Food Service 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) John Meding Mary Cotter 19b. Meiling Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles M. Reese (son) 113 Windcliff Road, Prince Frederick, MD 20678 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete 1X Buriel 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2/18/98 Silver Spring, MD 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 21. Signature of Funeral Service Lightsee Home, Inc. 20901 Silver Spring, MD 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete fntervel Between Onset and Death Immediete Cause (Finel disease or condition resulting in death) minutes Due to (or as a consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Jenesceace 24b. Were autopsy findings aveilable prior to 24a. Wes en eutopsy performed? completion of ceuse of deeth? 1 Yes 200 No 1 Yes 2 0 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 DER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

> Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated.

1 Yes 2 No

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

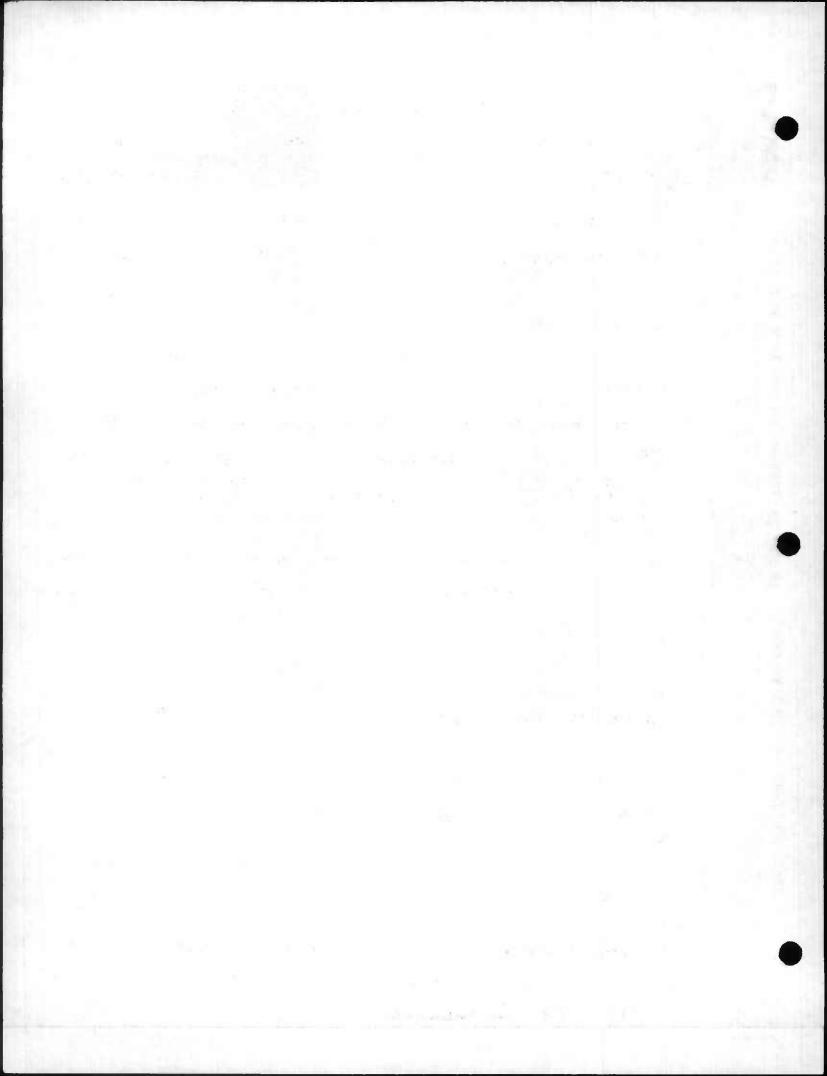


State of Maryland / Department of Health and Mental Hygiene

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Registrar

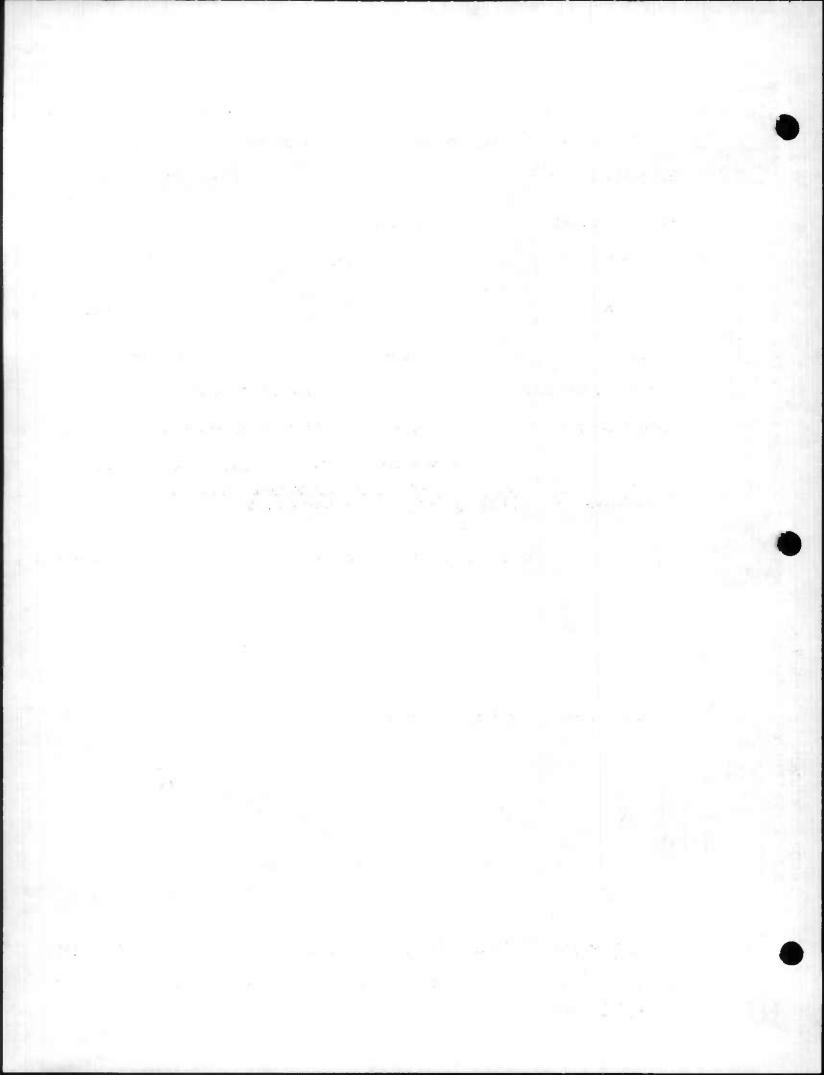
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State of Maryland / Department of Health and Mental Hygiene

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/Medical	ı		er E. Roo							FEBRUA			14:20_
Examiner		4a. Facility Nama							4b. City, Town, or L		th 4c. County	of Death	
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ath with the Marylar 23a or 28a-f show wat be notified at	2	WV	Mineral	L		Ridge	ley					1	□Yas 2√No
or 28a-f s be notified Director		10e. Straat and Nu	umbar				10f. Zip	Coda			10g. Citizan of	Whet Country?	
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Is m		19a. Informant's N					_		end Number or Ru			, Stata, Zip Cod	a)
em 27 ther tr		Richard 20a. Mathod of Dis	Rockwel	1-son	20b.	Rout Place of Disp	e 2 E	na of	419 Ridge	ley WV		- City or Town,	State
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Important: If I any Injury or once.	1 Qa	mes z	z &c	ara	ull.	Scar	pel	li Funera and MD 21	502				
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he Funeral D pletely filled i		29a. Cartifiar (Check only one)	1X Certifying P 2 Medical Exa	hyalclan: To tha b minar: On tha bas and manna	sis of axamina	owledge, deel ation and/or Ir	h occurrad wastigation	at tha tir , in my c	ma, data and placa, opinion, daath occur	and dua to the red at tha tima	causa(s) and m , data and place,	annar as stated and dua to tha	causa(s)
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_		D V	HMM)	~ alles	nd 1	W		D 1	6041		FEBRUAR	y 10.	1998
	-	30. Name end addi	rass of person who	completed cause	of death (Ite	m 23a) (Type	Print)	D 1	0071		LIDROAK	- 10 ,	2,7,0
LS		DR. TERI	RY WILLIA	AMS, MEMO	ORIAL F	HOSPITA	AL MEI	ICA	L BUILDIN	G, CUMI	BERLAND,	MD 2	1502
State	:	31. Data filed (Mor		A2. Re	gistrar's Signa								

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State of Maryland / Department of Health and Mental Hygiene 98 06883

						Cei	rtificate o	f Death			Reg. No).		0000
	٠	3	1. Decedent's Name (First, Middle, La	st)						2. Date of D	eath			3. Time of De
	nysici. Medic		Donald R. Rees							Month 02	20		Year 98	9:00
	xamin		4a. Facility Name (If not institution, give	e street end numbe	er)			4b. City, To	own, or L	ocation of Dea	th 4c	. County	of Death	
			23 Fourteenth St	reet				Pocomo	oke (City		Wor	cest	er
	neral ector		5. Social Security Number 6. \$ 009–18–8441	Sex 7.7	Age (In yrs. lest b	virthdey) Yrs.	If Under 1 Yes Months Day		24 Hrs. Min.	8. Date of Bi (Month, D 01/16/			9. Birthpi Count	iace (Stete or F try)
P >			Usual Residence of Decedent 10e. Stete 10b. County		10. Oh. Te									
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with to	2		10e. Street and Number				10f. Zip Code				10g. Ci		Vhat Coun	try?
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er de	Der	une	11. Meritel Status	12. Wes Deceder Armed Force	s?	13. \	Was Decedent of If Yes, specify Cu	i Hispenic Or ıban, Mexice	rigin? (Sp n, Puerto	pecify Yes or No Rican, etc.)	0-		e - America k, White, e	
UZO urs eft	Exami	by	1 ☐ Never Merried 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 I If Yes, Give Year or Detes	s: Korean		1□ Yes 2□XN	o Specify	:			Specify	whi	te
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Merker A	netic	To	Donald W. Rees							. Bello				
May 12 st 12 st 16 m	raun		19a. Informant's Name/Relationship (19		ng Address (Stre							
e, I end I ealt lealt	ther		Ruth R. Rees (Wif	fe)	20h Bisso		Fourteer	ith St	. P					
F Per Se	0 0		1 Burial 2 □ Cremetion 3 □	Removal from Stel	oom of	ery, cren	netory or other p	lece)	1	Date			City or To	
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- 202	8 0		Robert H. Bra	adshaw	au		06 W. Ma					. MD	218	17
	140	Н	23e. Pert1. Enter the diseese, or com shock, or heart failure. List only	plications thet caus	ed the death. Do	not ent	er the mode of d	ylng, such as	cerdlec	or respiratory	errest,			Approximate Interval Between
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			Immediate Cause (Final disease or condition	. Cor	DXIAR	7	decc	USI	DAG	,				
Lxaiii	200	ᆁ	resulting in death)	G	Due to (or as a	conseq	quence of):						1	
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Se se se se se se se se se se se se se se	leinno	<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	DI	ABETI	=5	ME	CHI	05					
os / ou,	the	edicai	that initiated events resulting in death) Last	0	Due to (or es e									
ortific ling	9	2		d										
Beth certi	or us	lan		0.									1	
The law requires that the deeth at the best been signed by the etter	should be deteched for us	Physician/	Part II. Other significant conditions of	ontributing to death	but not resulting	in the ur	nderlying cause (given in Pert	l.	23b. Did	tobacco	use con	tribute to	the cause of d
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e lew I	CI .) E											of c	npletion of caus leath?
5 to 8	director, page	5								10	Yes 2	No	1 🗆	Yes 2 No
DIVISION OF VITAL RECORDS, or Attanding Physician: The lew requires that death. Director: After this certificate hes been signe	ctor,	Be	25. Was cese referred to medicel examiner?					28. Plac	e of Deat	th (Check only	one)			
Attending Physician: or death. ector: After this certific	dire	2	1 Yes 2 No	Hospital: 1 Inpa	tlent 2 ER/C	utpatien	t 3 DOA	other: 4 N	ursing Ho	ome 5 Res	Idence	8 Othe	r (Specify)
ng Pi	nera		27. Manner of Death 1 Netural 5 Pending	28a. Date of In (Month, D	jury 28b.	Time of Injury	28c. Inj	ury et ork?		28d. Describe	how inju	ry occurr	ed	
uttandir death. ctor: Af	he tu	atic	2 ☐ Accident investigation	1		,,		☐ Yes 2 ☐	No					
OIVISION I or Attanding after death. Director: After	5	Certification:	3 Suicide 6 Could not be determined	28e. Place of I	njury - At home, t	arm, str	eet, factory, office	В		28f. Location			er or Rurai	Route Number
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Lo the Hospital or A within 24 hours after To the Funeral Direction	completely tilled in by the tuneral	edical	29a. Certifier (Check only one)	ysician: To the bes ninar: On the basis and manner:	of examination a	e, death nd/or inv	occurred at the restigation, in my	time, date ar opinion, des	nd plece, eth occur	and due to the red at the time	cause(s , date an) and mad d place, a	nner as stand due to	ated. the cause(s)
o kitig	moc	M	29b. Signature and title of certifier	1				nse number	-		29d. De	te signed	(Month, L	Dey, Year)
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		1	30. Name end address of person who	completed course of	deeth (Item 22-1	(Tuna	Print\					100	12	
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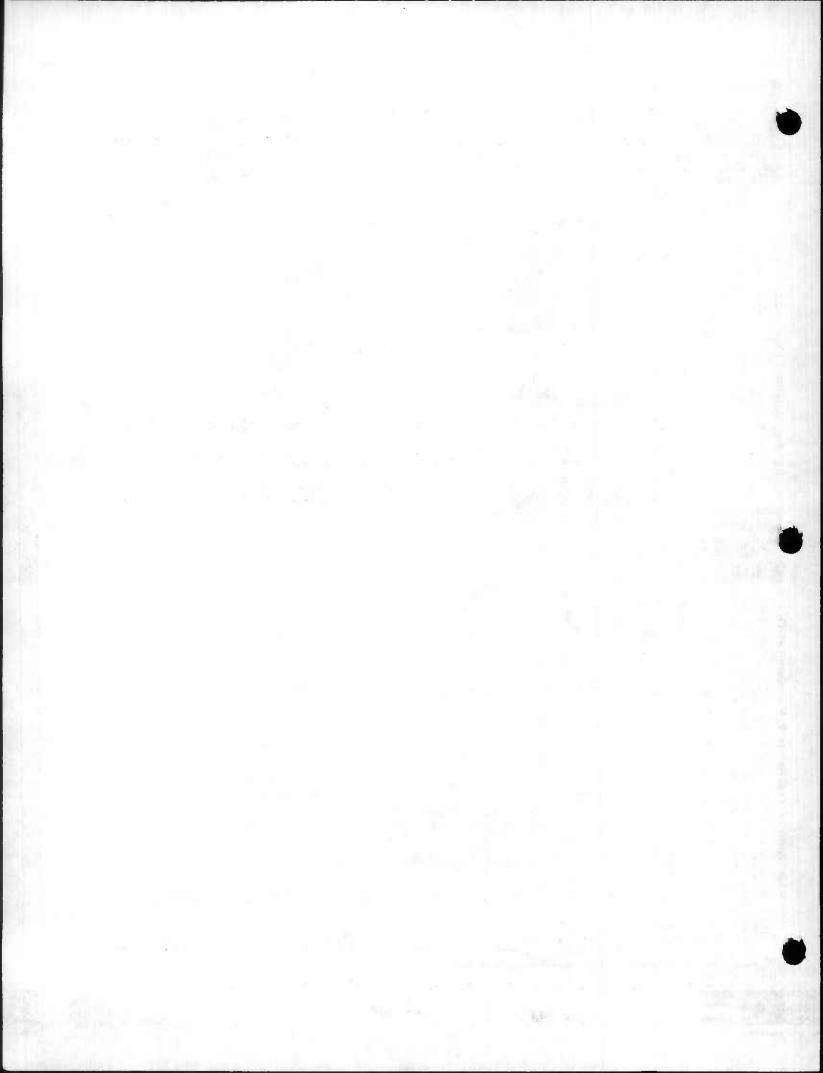
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otate of Mary		Certificat				Reg. No.	0 00084
	Physic /Medi		1. Decedent's Neme (First, Middle, Las) /	a Berl	e RUGH			2. Dete of D Month	Dey	Yeer 12:03 Am
	Exami		4e. Fecility Neme (If not institution, give	street and number)				4b. City, Town, or	Location of Dee	th 4c. County	
		. 1	Garrett County M	emorial Hosp	pital			0ak]	land	Ga	arrett
	Funeral Director		5. Sociel Security Number 6. Security Number 167–09–3747 Usual Residence of Decedent	7. Age (In 81	yrs. last birth Y	mday) If Under Months	Deys	If Under 24 Hrs Hours Min	. (Month, D	irth ey, <i>Year</i>) 2, 1917	9. Birthplece (State or Foreign Country) Pennsylvania
	ryland		10a. Stete 10b. County	100	c. City, Town	or Location					10d. Inside City Limits
	e Me	cto	PA Allegh	eny	0.	akmont					1 X Yes 2 □ No
	or 28	Director	10e. Street end Number			10f. Zip	Code			10g. Citizen of	Whet Country?
	23a	a	232 Washington A	ve.				15139		US	SA
21215-0020	72 hours efter death with the Meryland "natural", or frems 23a or 28a-f show idical Examiner must be notified at	by Funeral	11. Merital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	In U,S.	13. Wes Deceder of Yes, specific Yes, specific Yes		lispenic Origin? (Sen, Mexicen, Puer Specify:	Specify Yes or N rto Rican, etc.)	o- 14. Red Ble Specif	ce - American Indian, ck, White, etc. White
0-10	in 72 ho	ted	15. Decedent's Ed	ucetion	16a. [Decedent's Usu	el Occup	etion		16b. Kind of B	usiness/Industry
218	E 2	Completed	(Specify only highest gred Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of wo life. DO NOT u	rk done se retire	during most of wo	orking		
21	D Co	E O	8th	College (1-401 5+)		House	wife				Home
pu		Be	17. Fether's Neme (First, Middle, Last)					18. Mother's Ne	me (First, Middle	, Maiden Suman	ne)
Maryland		To	Richard M.	WILL:	S			Bertha	a M.	Nee	ely
ar	d 2 should thend Mer 7 is merke traumatic		19e. Informent's Neme/Relationship (T	ype, Print)	19b. l	Mailing Address	(Street	end Number or Fl	lure/ Route Numi	per, City or Town	Stete, Zip Code)
	C = 8 -		Ralph H. Rugh/Hus	band	23:	2 Washi	ngto	n Ave.,	Oakmont	, PA 15	139
altimore,	it of Heall If Item 2 or other		20e. Method of Disposition 1 ☐ Burial 2 X Cremetlon 3 ☐ I		b. Plece of [Disposition (Nar cremetory or c	ne of		Dete		City or Town, State
Ĕ	Peges nent of ant: If its ury or o		4 Donetion 5 Other (Specify,		dvance	ed Crema	atio	n Ser.	2/15/98	Boston,	Pennsylvania
Balt	permit. Peges Department of Important: If it eny injury or o	g physician es the purial-transit can line. Examiner es the purial-transit can line.	21. Signature of Funerel Service License			22. Neme er	d Addre				
_	70 % • Q		Budley H. W	Sie		32 S.	Sec	ond St	Oaklan	d. MD 2	1550
П			23a. Pert1. Enter the disease, or comp shock, or heert feilure. List only o	licetions that caused the	deeth. Do no	t enter the mod	le of dyin	g, such es cerdia	c or respiretory	errest,	Approximete fntervel Between
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	e. Casal	Awen to	Fail VE	Pa	yteside C	whether	at failur	Onset and Deeth
Box 68760,	certificate be executed adding physiclen and use as the burial-transit		Sequentielly list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In deeth) Last	c. Smil Bank	1 06	Myormaliansequence of):	In land	/Pashble	Sepsis	KNEWT &	3-5 days
Ď	death cer e attendir ed for use	cla	Pert II. Other significant conditions co	ntributing to doub but not	reculting in t	ho undodvina o	auga gir	on In Post I	23h Did	tohacca uso co	ntribute to the cause of death?
, P.O.	t the by th	y Physician/N	Total of a significant conditions out	minuting to death but not	resulting in t	ne diloenying c	euse giv	erin reici.		TALLOC ST. L.	3 □ Probably 4 ☒ Unknown
Records,	2 S S	hes been signed be 2 should be d							24e. Wes	en eutopsy ormed?	24b. Were autopsy findings evelleble prior to completion of cause of death?
	The ate h								1 🗆	Yes 2♥No	1 ☐ Yes 2 ☐ No
Vital	ysician: The s certificate director, pag	Be	25. Wes case referred to medical exeminer?					26. Plece of De	eth (Check only	one)	
of	5 0 0	2	1 ☐ Yes 2 No	8.6	2 ER/Outp	atlent 3 DC	Oth	er: 4 Nursing I	Home 5□Res	idence 6 □Oth	er (Specify)
Division o		Certification:	27. Menner of Deeth 1 ☑ Naturel 2 ☐ Accident 5 ☐ Pending investigation	28e. Dete of Injury (Month, Dey Yea	28b. Tir Inju	ne of 2	8c. injun Worl	/ et k? Yes 2 □ No	28d. Describe	how injury occur	red
N N	the Hospital or Attending hin 24 hours effer death. the Funeral Director: Afte npletely filled in by the fune		3 Suicide 6 Could not be determined	28e. Plece of Injury - / bullding, etc. (Sp	kt home, farm ecify)	n, street, factory	, office		28f. Location City or To	Street and Numb wn, State)	per or Rurel Route Number,
	e Hospital	edicai	29e. Certifier (Check only one) 1	elcfan: To the best of my ner: On the basis of exen end menner steted.	knowledge, on Ination end/	deeth occurred or Investigetion,	et the tim In my o	ne, dete end plece pinion, deeth occu	e, end due to the urred et the time,	cause(s) and me date end place,	anner es steted. end due to the ceuse(s)
	To the within 2 To the comple	Me	29b. Signeture end title of perifiet			290	. License	number		29d. Date signe	d (Month, Day, Year)
			(NA)V				14-	7925		2/12/	1998
			30. Name end eddress of person who co	ompleted cause of death /	Item 23a) /T-	vne Print)	1 1/	10)		-/12/	
		5	Dr. Charles A. Wal					001-1 1	M = 1	m.J. 015	FO
	Sta	e	31. Dete filed (Month, Day, Yeer)	32. Registrar's S		ouren S	0 [0]	Oakland	, maryla	and 215	OU
	Registr		TER 1 0 1	ogo Mil	and sound	Rachall.					



State of Maryland / Department of Health and Mental Hygiene

							Cer	tificat	e of	Death			Reg. I	No.	j (j	00	00
Dhuaisian		dent's Name (F	First, Middla, La	st)				5 10				2. Date of Month	Death	No.	Vear	3. Time	of Death
Physician /Medical	H 7	ceida L	enora R	loth								Worth ()2 '	Day 14	Year 98	10	:59 a.
Examiner	4a. Facil			e street and num		bij.				4b. City, To	own, or L	ocation of De	ath 4	4c. County	of Death		
	-			MEMORIA							LAND	_		GARRE	TT		
Funeral Director	378	-05-168	31	Sex I□M 2【XTF	7. Age (In 99	yrs. last bir	thday) Yrs.	If Under Months	1 Year Days	If Undar Hours	Min.	8. Date of (Month) AUG 21	Birth Day, Yea 1	ar) 898	9. Birthpla Counti MIC	V)	e or Foreign
nours arter death with the Maryland ural', or flems 23a or 28a-f show at Examiner must be notified at d by Funeral Director	10a. Sta	esidence of De-	b. County		10	c. City, Tow	n or Loc	ation							10	d Inside	City Limits
of sh	MIC	Н	IONIA					DESS	Α								s 2 No
or 28a-f show be notified at Director	10e. Str	et and Numbe	r					10f. Zip					10a. (Citizen of V	Vhat Count	rv?	
° N O		9 EMERS	SON STR	EET					4884	19				SA		,	
r items 234	11. Mari	tal Status		12. Was Dace	dant Evar	in U,S.	13. W	/as Deced	lent of H	lispanic Or	igin? (Sp	ecify Yes or		14. Rac	a - America		
by by	3 🔯	Never Married Widowed 4		Armed For 1 Yas If Yas, Give Year or Da	2 🔼 No a				-	Specify:		Rican, etc.)		Specify	k, White, e		
Ygens. Note than "natural", It the Wedical Eva Completed by		15. (Specify o	Decadant's Econly highast gra	ducation ide completed)		16a.		ant's Usua		ation during mos	t of work	ina	16b.	Kind of Bu	isiness/Indu	ustry	
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yor			remation 3 [] Other (Specify	Ramoval from S		cemetei MENNO:		atory or o									
any Injury			Service Licen			MENNO.				ss of Facili	lv				MICH.		
any injury or other	1	10.9	WIII	7. 1	-	0167								BOX 2			
	23a. Pa	rt1. Enter the d	isease, or com	olications that ca		0167	not ente					ME - O		ND, M		Approxim	ata
sician	she	ock, or heart fai	ilura. List only	plications that ca one causa on ea	ich line.				a or ay	9, 30011 03	0610160	or reopilatory	arraot,			Intarval B Onsat an	etween
dical	Immedia	ite Cause (Fina	nI-														
niner	rasulting	or condition in death)		a. Conge		to (or as a			re_						12	day	S
je je				b Coron											v	oora	
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FX EX		lally list condition ading to immediate underlying	diate				- 1								i		
es the burial-transit	that initia	Disease or Injurated events in death) Last	у 🐪	C	Due	to (or as a c	onsequ	ence of):		-							
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etached for us Physician/	Part II. O	ther significan	t conditions o	ontributing to dea	ath but no	t resulting Ir	the un	derlying ca	ausa giv	en In Part I		23b. Di	d tobace	co use cor	tribute to t	the caus	e of death?
Phy												10	Yes	2™ No	3 Probe	ably 4	Unknown
2 2																	
page 2 should Completed												24a. Wa	as an au normed?	topsy	24b. Wer avai	e autops labla prio pletion o	r to
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Co												1[Yas	2 🖾 No	10	Yes 2	□ No
director, page To Be Com	exam	case referred to	o medical	Hospital:					0.1		of Daat	h (Check ont	y ona)				
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ion	1 🔯		Pending		Day Yea		ime of njury		Bc. Injur			28d. Describ	e how in	jury occurr	ed		
the		Accident Suicida 6	Investigation Could not be		41-1	***		M		Yes 2		00(1	(0)	484 1			
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ಕ	D	/ Folan	hlin	И					0334					02/14		y, 10a/)	
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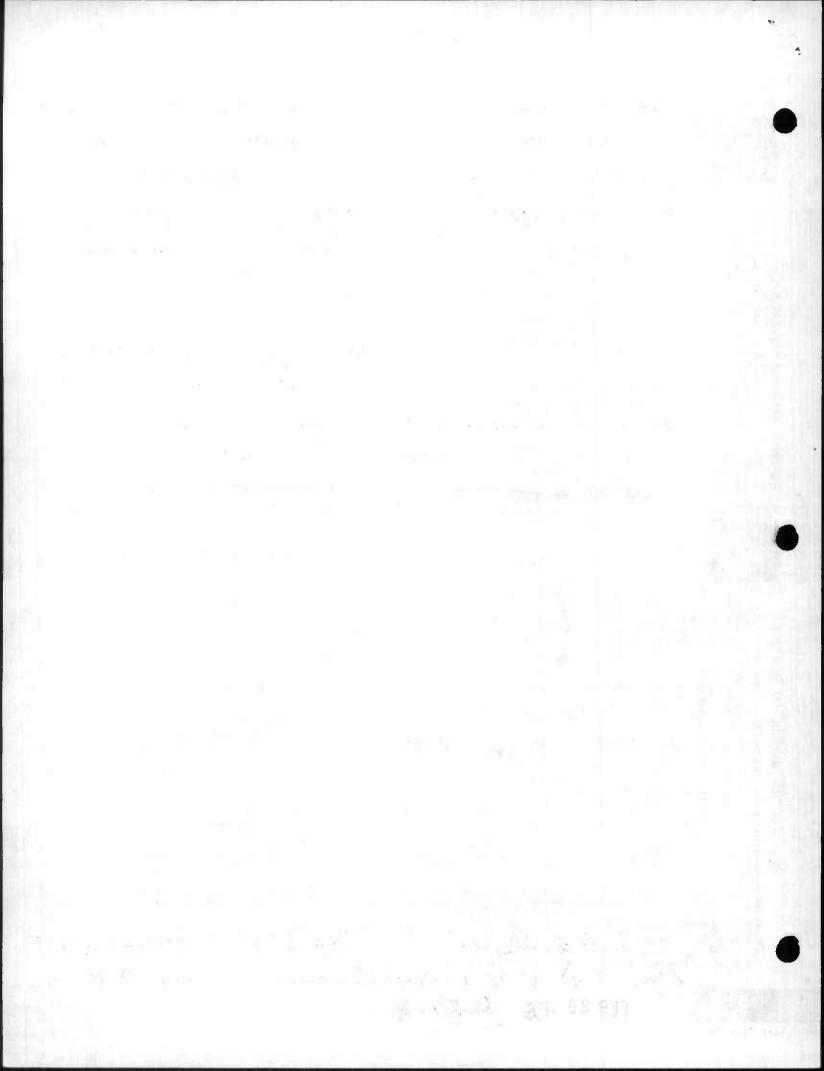
DHMH 16 Rev 6/95

Transfer of the Lines

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		Decedent's Name	(First Middle				tificate of	Death	, ,	eg. No. 9 E	0	5886 3. Time of Deal
Physici	an								Month	Day	Year	
/Media				mallwood	han)			4b. City, Town, or L	January	_		04:19a
Examir	ner	4a. Facility Nema (If n			iber)					4c. County		
45		Shady Gr			7. Ama //a	land hilabata da d	tf Under 1 Year	Rockvil tf Under 24 Hrs.			gome	
Funeral Director		5. Sociel Security Nur 577–20–0 Usual Residence of D	123	3. Sex 1 □ M 2 ∏ F	7. Age (In yrs. 89	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) Mar. 23			ace (State or For ry) NC
faryland season	or	10a. State	10b. County	Georges	10c. Ci	y, Town or Loc	vattsvil	le			10	d. Inside City Lin
28a	ect	10e. Street and Numb					10f. Zip Code			0g. Citizen of W	Shot Count	- 1
23a or	Funeral Director	6500 Rig		đ				0783		United		•
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Appiene. If Health and Mental Appiene. Other Traumatic event, the Medical Examiner must be notified at other traumatic event,	by	11. Maritel Stetus 1 □ Never Married 3 □ Widowed 4		12. Wes Deced Armed Ford 1 Yes 2 if Yes, Give Year or Da	ces? 2/2 No		/as Decedent of H Yes, specify Cuba ☐ Yes 2 No	lispanic Origin? (Sp an, Mexicen, Puerto Specify:	pecify Yes or No- o Rican, etc.)		- America c, White, e	
2 should be filed within 72 hours aft and Mental Hygienal Hygienal is marked other than "natural", or surrette event, he Medical Evann	Completed	(Specify Elementery/Second		Education grade completed) Cotlege (1-	4or 5+)	(Give I	ent's Usual Occup kind of work done O NOT use retired	during most of world	king	16b. Kind of Bu	stness/Ind	ustry
ygien ygien f, th	Co	12th					Domesti	=		Private		ustry
doth ven	Be	17. Father's Name (Fi					M		ne (First, Middle, I		e)	
Men	10	Joshua J	ohnson					Mary	Etta May	70		
and is m		19a. Informant's Nam	e/Relationshi	p (Type, Print)		19b. Mailin	Address (Street	and Number or Ru	ral Route Number	, City or Town,	State, Zip	Code)
ealth n 27 ner tr		Jacqueli	ne Joh	nson - Gr	nddaht	r 732	1_12th_S	treet. N.	W. Wash	DC 2	20012	-1707
r of H		_		Removal from S	1	Place of Dispos cemetery, crem	ition (Name of atory or other place	00)	Date	20c. Location - 0	City or Tov	vn, State
nent int: h		4 Donation 5				larmony	Memoria	1 Cem.	1/23/98	Landov	er,	MD
Department of Health Important: if item 27 eny injury or other tr		21. Signature of Fune	oral Service Li	censee			Name and Addre	ss of Facility	Morticia	ans, Inc	2.	
		23a. Part1. Enter the	10 %	torlow								0011 Approximate
xamlner pura li-transit	as the burial-transit edical Examiner est and a second as a second	diseesa or condition resulting in death) Sequentially list cond if any, leading to imm	itions,	a. [JV]	Due to (d	or as a consequence as a consequence	ience of):	ardioi	430014	v .0.194	10 6	
ste hes been signed by the attending physician and page 2 should be detached for use as the burial-transit		Sequentially list cond if any, leading to imm ceuse. Enter Underly Ceuse (Disease or inflatatinitiated events resulting in death) Last	ring lury st	c	Due to (o	r es a consequ	ence of):					
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ite hes page 2	MO								1 □ Ye	s 2 No	1 🗆	Yes 2□ No
	BeC	25. Was cese referred	d to medicet					26. Place of Dee	th (Check only on			
s certificete he director, page	To B	examiner? 1 ☐ Yes 2 ☐ No		Hospital:	patient 2 🗂	ER/Outpetient	3□ DOA Oth	or	ome 5 Reside		r (Snacih	
<u>₽</u> <u>₽</u>		27. Menne of Deeth	5 Pending	28a. Date of (Month)		28b. Time of injury	28c. Injur Wor		28d. Describe ho			
24 hours efter death. Funeral Director: After	Certification:	3 ☐ Sulcide 4 ☐ Homicide	6 Could no determin	ad 200. Place 0	of Injury - At hig, etc. (Specif	ome, farm, stre	et, factory, office		281. Location (St City or Town	reet and Numbe n, State)	or Or Rural	Route Number,
Funer Funer tely fill	edical (29a. Certifier 1[(Check only 2[one)	Certifying Medicel Ex	Physician: To the bas aminer: On the bas and manne	is of examine	wiedge, death tion and/or inve	occurred at the tin estigation, in my o	ne, date and plece, plnion, death occur	and due to the ce red at the time, do	euse(s) and mer ate and place, a	ner as sta nd due to	ited. the cause(s)
within To the comple	Me	29b. Signeture and in	e of certifier		. /		29c. Licens			9d. Date signed		
3 - 0		V/2	01	2. 14.	1		V	01250	JIV AL	FERDU	41.	191941
		30. Name end address	s of person wi	no completed cause	of death (item	1 23a) (Type, F	rint)	01852	0.	11, 17	11	10 MA
Star Registra		31. Date filed (Month,	Day, Year)	1000 32. Reg	pistrar's Slone	ture	squee	110000	7 . 60	17990	מיטכו	2070

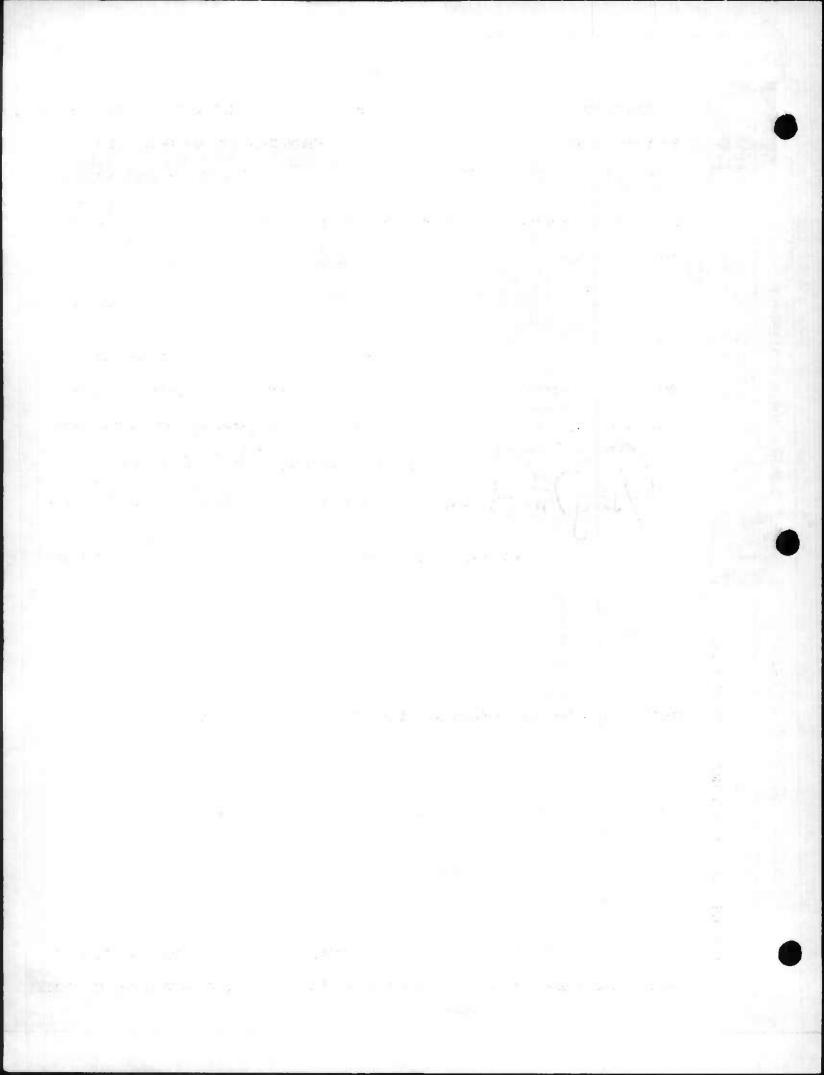
DHMH 16 Rev 6/95



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				Oldio Ol	Marylan	•	rtificate d	of Death		g. No.		
	D 1		1. Decedant's Name (First, Middle,	Last)					2. Date of Deet Month	h Dey	Yeer	3. Time of Deeth
۰	Physic /Medi		COURTLAND				STOTT		FEBRUAR		1998	7:11 A.M
	Exami		4e. Fecility Neme (If not institution, g	rive street end num	ber)			4b. City, Town, or		4c. County		
7			9646 DUFFER WAY					MONTGOMER	RY VILLAG	E MONTO	COMER	Y
т	Funeral				. Age (In yrs. le	last birthdey)	If Under 1 Ye	ear If Under 24 Hrs.	8. Date of Birth (Month, Dey,			plece (Steta or Foreign ntry)
	Director		715-14-9549 Usual Residence of Decedent	1∏ M 2□ F	82	Yrs.	Months Da	ays Hours Min.	Nov 24,	1915		sylvania
	death with the Maryland		10e. Stete 10b. County		10c. City	, Town or Lo	ocation					I Od. Inside City Limits
	the Maryler 28a-f show	to	Maryland Montgo	merv	Mor	rtoome	ry Vill	ace				1 ☐ Yes 2 ☐ No
	th with the Maryle 23s or 28s-f shoust be notified at	rec	10e. Sfreet end Number				10f. Zip Cod		10	Og. Citizen of	Whet Cou	ntry?
	23a or	Q I	9646 Duffer Way				208	96		United	d Cto	ton
	death	Jera	11. Marifal Status	12. Wes Deced	dent Ever in U.S	S. 13.		of Hispenic Origin? (S Cuben, Mexican, Puert	pecify Yes or No-			can Indian,
21215-0020	or its	by Funeral Director	1 Navar Married 2 Married 3 Nidowed 4 Divorced	Armed Ford 1 Yes 2 If Yes, Give Year or De	No No		If Yes, specify (1 ☐ Yes 2 🛣		o Rican, etc.)	Specif.	ck, White,	etc. nite
0	72 hours "natural",	Po	15. Decedent's			16a. Dece	dant's Usuel Oc	ecupetion		16b. Kind of B		
15	- 4	Completed	(Specify only highest	rede completed)	4 5 3	(Give	kind of work do DO NOT use re	one during most of wor	rking			
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Maryland	2 should be end Mental is marked o	To B	Emil S	ein				Flore	nce '	Viola	C	tott
N.	should by and Menta	-	19e. Informant's Neme/Reletionship	(Type, Print)		19b. Maili	ing Address (St	reet and Number or Ru				
	end 2 : saith er n 27 is er trau		Joan B. Stott,	Wife				Way, Mont				20886
ē,	Health Health tem 27		20e. Method of Disposition	WILL	20b. Pl	eca of Dispo	osition (Neme o	1		20c. Location		
Baltimore,	permit. Pages Department of I Important: If ite any injury or of once.		1 ☐ Burier 2 OCremation 3		tete		metory or other	T.	eb. 14,			
三	it. P		4 □ Donetion 5 □ Other (Special Signature of Funeral Bervice Line	/	Met	3			1998	Alexand	iria,	Virginia
Ba	Dependant Mark	Department of Health Important: if item 27 any injury or other ti once.	21. Signature of Fullerat Berviol Ca	1		2	z. Name end Ad	ddress of Fecility	DeVe	ol Fune	eral	Home
			Theres!	n. 7	ni			er Park Dr			g, MD	
			23a. Pert1. Enter the disease or co shock, or haert feilure / List on	mplications thet ca y one ceuse on ae	used the daath ch lina.	. Do not en	ter the mode of	dylng, such es cardied	or respiretory erre	est,		Approximate Interval Batween
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	/Medical Examiner		Immediate Ceuse (Finat disease or condition rasulting in death)	e. CORO	NARY AR	RTERY	DISEASE					5 YEARS
		-	resulting in death)		Due to (or	as a conse	quenca of):					
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	deeth certificate be axecuted e ettending physician end of or use as the buriel-transit (M.E.)	кап	Sequentially list conditions,		Due to (or	es e conse	quenca of):					
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87	icete be ay physician s the burie	dica	thet initiated events resulting in deeth) Lest	Ç.	Due to (or	es e consec	quence of):					
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	requires that the		CHRONIC LUNG DIS	EASE, FA	CEPIANEN	C, DIA	DETES		X			
Records,	v require	Completed by							24e. Was an	autopsy	24b. W	era autopsy findings reliable prior to
S	D 00 4	pie					_		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		CC	mpletion of cause death?
E	The law ate has page 2	Eo							1 ☐ Ye	s 2 No	11	JYes 2□ No
Vital	certificate rector, pag R. M.	Be C	25. Wes case referred to medical					26 Place of Dec	eth (Check only one		J.,	
>		To B	examiner? 1 XYes 2 No	Hospital:	patiant 2 2 E	FR/Outpetie	nt 3 DOA	Other	lome 5 🕱 Reside		ner (Sneci	(v)
of	는 문교		27. Menner of Death	28e. Dete of (Month		28b. Time o		njury et Work?	28d. Describe ho			,,
Division		Certification:	1 XNaturel 5 ☐ Pending 2 ☐ Accident Investigat		, Dey Year)	Injury		Work? 1 ☐ Yes 2 ☐ No				
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Ö	after Direction of ASE	erti	4 Homicida determine	building	g, etc. (Specify))	, , , , , , , , , , , , , , , , , , , ,		City or Town	, Stete)		
	Hospital or 24 hours afte Funeral Dir staly filled in XELEAS		29a. Certifier 1 X Certifying I	hyelden: To the h	act of my know	vladas daati	h accurred of th	e fime, defe end plece	and due to the ce	use/s) and m	00007.00	teted
	Fun Fun etaly	edical			is of exemineti			ny opinion, deeth occu				
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	To the Hospital of within 24 hours a To the Funeral D completaly filled i		30. Name and address of person wh				, i					
			DENNIS C. FRIEDA	IAN, M.D.	, 15225	SHAD	Y GROVE	ROAD, SUI	TE #201	ROCKVII	LE,	MD 20850
	Sta Registr		31. Dete filed (Month, Dey, Year) FEB 17 19	38	gistrar's Signati	- About	عاد					

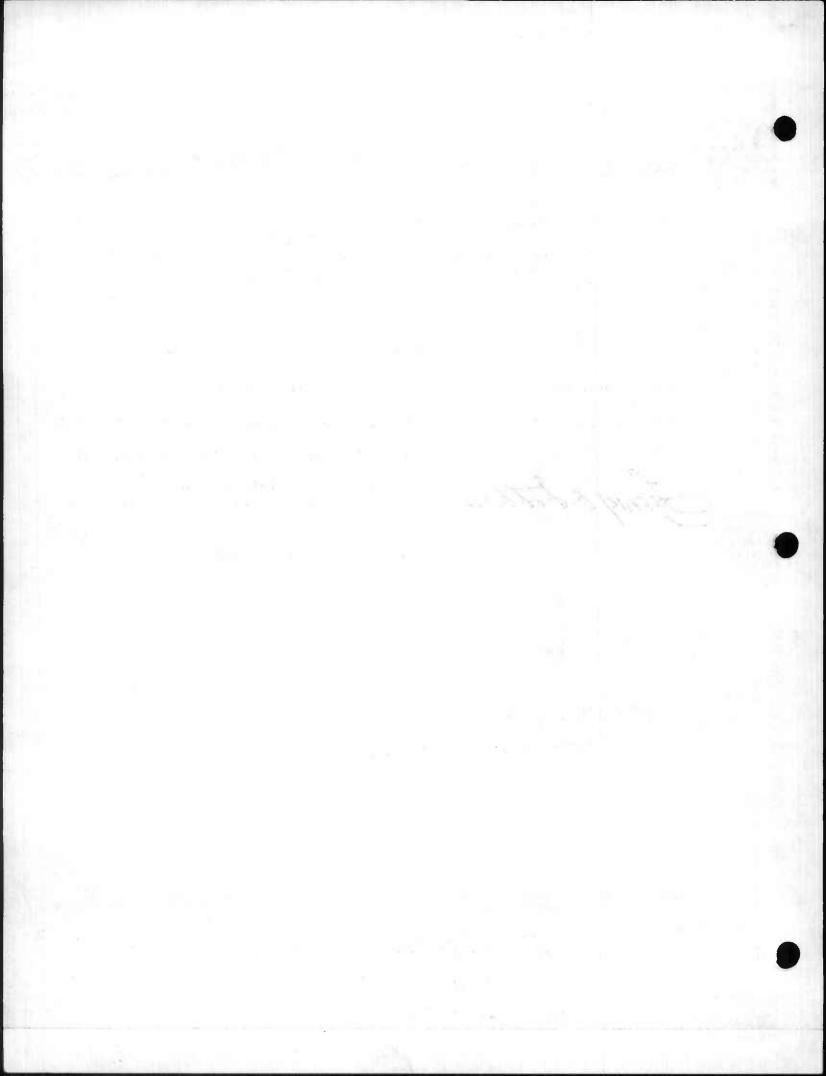
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 8 0588

						Certificate of	Death		Reg. No.	08000
	Dhunia	1	1. Decedant's Name (First, Midd					2. Date of De		3. Time of Deeth
	Physic /Medi		Vivio	an Sal	azar			Febru	eary 14	1998 2:42 PM
}	Exami		4e. Facility Name (If not institution	on, give street and number)	1 11	- 1	4b. City, Town, or Lo	1		of Death
			Laurel	Regional 1	TOSPIT			irel	Princ	ce George's
ı	Funeral Director		5. Social Security Number 578-56-4573	6. Sex 7. Age 1	(In yrs. lest bi	rthdey) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Jan	rth 23, 1942	9. Birthplaca (Stata or Foreign Country) Washington, Do
	pue *		Usuai Residence of Decedent 10a. Stata 10b. Count	v	10c. City, Tow	m or Location				10d. Inside City Limits
	Aaryle	5		ce Georges	Laure					1 ☑ Yes 2 ☐ No
	the 1	ect C	10e. Street and Number	ee dearges	Baul	10f. Zip Code		I	10g. Citizan of V	/hat Country?
	3a or	Funeral Director	200 Fort Mead	e Road Apt.	#207	20707			United :	
	death	nera	11. Marital Status			13. Was Decedent of I	Hispanic Origin? (Sp	ecify Yas or No)- 14. Race	- Amarican Indian,
5-0020	s 1 and 2 should be filed within 72 hours effer death with the Maryland Health and Mantal Hygiene. Then 27 is marked other than "natures", or items 23a or 28a-f show other traumatic event, the Medical Examinating the notified at	by	1 ☐ Never Married 2 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Give		1 Yes 2 No		Hican, etc.)		k, White, atc. Black
5-0	72 ho	Completed	15. Decede (Specify only high	nt's Education est grade completed)	16a	Decedent's Usual Occup (Give kind of work done	pation during most of work	ina	16b. Kind of Bu	siness/Industry
2121	within lena. than	mpi	Elementary/Secondery (0-12)	1	•)	(Give kind of work done life. DO NOT use retire Homemaker	d)		Home	
2	Hygie Hygie ont, th	ပိ	12 17. Fether's Nama (First, Middle	Last		iomemake1	18. Mother's Nem	Circl Middle		-1
an	ould be filed Mantal Hygi arked other atic event,	Be C	William Short				Hazel T		i, ivierden Surnein	6)
Maryland	and Man is marke	Lo	19a. informant's Neme/Relation		191	o. Malling Address (Street			ver City or Town	State 7in Code)
	nd 2 state and 27 is r trau		Luis Clavell	(Son)		917 Firth Ro			-	
e,	of Health		20a. Method of Disposition			f Disposition (Neme of ry, cremetory or other pie		Dete		City or Town, Stete
E	0 = 0		1 Burlei 2 Cremetion 4 Donetion 5 Other (Dlivet Cemet	ery 2	/21/98	Washing	ton, D.C.
Baltimore,	Department of mportant: If any injury or ance.		21. Signature di Funerei Service	Licenso	47	22. Name and Addre McGuire Fu	ess of Facility		Γ	
B	88E88	1	Herri S.	Pollie						n, D.C. 20012
			23 Part 1. Entar the disease, c shock, or heart failure. Lis	or complications that caused	ha daath. Do					Approximata Intervei Between
Л	Physician		Shook, of Hydr (tallets. Els	- Corny one cause on each min						Onset and Death
4	/Medical		Immediata Causa (Final disease or condition resulting in death)	. (2)	Womi	CYSTIS	PMEU	MONI	A	*
П	Examiner	L	resulting in death)			consequence of):	1	, ,	70	
	pe tis	를		b	710:	5				
	rtificate be axecuted ng physician and s as the buriel-transit	Examiner	Sequentially list conditions, if any, leeding to immediate		ue to (or as e	consequence of):				
68760,	be a sician burie		Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initieted events	с						
687	ficate phys	Medical	resulting in deeth) Lest		ue to (or as a	consequence of):				
Box	nding use a			d		_				
	death ce e attandii d for use	Physician/	Pert li. Other significant conditi	ions contributing to death but	not resulting i	n the underlying ceuse di	ven in Pert i	23h. Did	tobacco use cor	itributa to the cause of death?
P.0	that the dailed by the a	hys	HURMO	MISIM)		y.			Yes 2 No	3 Probably 4 Unknown
	as that	by F	1171/0//10	300/10/0						
of Vital Records,	been s	Completed	(MM)	ny moion,	y V	150A56			an autopsy ormed?	24b. Were autopsy findings evailable prior to complation of causa of deeth?
E.	The law ate has page 2	E						10	Yes 2☐No	1 ☐ Yes 2 ☐ No
ita	ysician: The l is certificate ha director, page	Be	25. Wes casa referred to medica axaminer?	al			26. Place of Deat	h (Check only	one)	
) \	Physician: rthis certific rrai director,	2	1 ☐ Yes 2 € No	Hospital: 1 Inpatien	t 2□ER/0	utpetient 3 DOA	ner: 4 Nursing Ho	ma 5□ Ras	idenca 6 □Otha	ar (Specify)
	ding Phys h. After this funeral d	on:	27. Manner of Death 1 ☐ Neturei 5 ☐ Pendi	ng 28e. Date of injury (Month, Dey	Year) 28b.	Time of 28c. inju injury Wo		28d. Describe	how injury occurr	ed
Division	Attending or death.	Certification:	2 Accident invest 3 Sulcida 6 Could	igation			Yes 2 □ No		(2)	
Σ	or At after of Direct in by	E	4 Homicide determ	mined 28e. Place of inju- building, etc.	y - At home, fa (Specify)	arm, street, factory, office			wn, Stete)	er or Rurel Route Number,
_	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Ö	29e. Certifier 1Pl Certifyi	ng Phyaiclen: To the best of	my knowledou	death occurred at the ti	me date and place	and due to the	causa(s) and ma	nner as stated
	Hos 124 h Fun letaly	edicai	(Check only 2 Medical one)	Examiner: On the basis of and manner stat	xaminetion er	d/or investigetion, in my	ppinion, death occur	ed at the time,	dete end piece, a	and due to the ceuse(s)
	Vithin Fo the	Me	29b. Signature and title of certific	er	1	29c. Licens	se numbar		29d. Data signed	(Month, Day, Year)
	12		> mail	1 IM est	en Y	n() 1 ()1	9220)	2-1	5-98
	10		30. Name end address of person	who completed ceuse of de	eth (item 23e)	(Type, Print)		,	<i>V</i> - 1	1
_			Neil A. Me	ade 9811	Mallo	and Driv	e Laura	1 M.	rylan,	1 20708
	Sta		31. Date filed (Month, Day, Year) 39 Registra	's Signature				1	
	Registi	ar	FEB 19 1	338 guguna	iden 18	ndell.				

DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene

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caminer	4	e. Fecility Neme (If not institution,	give street and num	ber)			4b. C	ty, Town, or	Location of Death	4c. County	y of Deeth	
	L	NATIONAL N	NAVAL MEDI	CAL CE	NTER			BETHE	SDA	M	ONTGO	MERY
nerai ictor		248-84-9227	6. Sex ★★M 2□ F	48 48	lest birthdey) Yrs.	If Under 1 Months [ours Mir		7, Yeer) 1949	9. Birthp Cour Sout	lece (State or Foreightry) h Carolin
12	-	Jsual Residence of Decedent 0e. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limit
ctor	L	Virginia Staff	ord	Fa	almouth	1						1 Yea 2 X
Sire or	1	0e. Street end Number				10f, Zip C	ode			10g. Citizen of	Whet Cour	ntry?
al la		400 Clubhouse	Road			22	2406			United	d Sta	tes
eny Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1	1. Maritel Status 1 Never Merrled 2 Marrle 3 Widowed 4 Divorced	12. Wes Deced Armed Ford MXYes 2 If Yes, Give Yeer or Det	ces? 2 □ No		Was Deceder If Yes, specify X 1 ☐ Yes X		lc Origin? (exicen, Pue ecify:	Specify Yes or No- rto Rican, etc.)		ce - Americ ck, White,	etc.
pted		15. Decedent's (Specify only highest	Education		16e. Deced	dent's Usuel (kind of work of DO NOT use	Occupation	most of un	arkina	16b. Kind of B	usiness/in	dustry
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trau	'	9a. Informant's Name/Reletionshi Mande Satterfi		e					Ru <i>rel Route N</i> um <i>be</i> Falmouth,			Code)
ther	20	0e. Method of Disposition		20b. P	-			(u., 1	Dete Dete	20c. Location	22406 • City or To	wn State
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5	-	4 Denation 5 Other (Sports)		A					2/11/98	Arli	ngton	, VA.
ony in	1	Vak XD	/			Name end /						
	Physician/Medical Examiner see the control of the c	23a. Pert1. Enter the disease, or c shock, or heart failure. List o		tion and the ment	3	3901 N.	Fair	fax I	or. Arl.,	Va. 222	203	Approximete Intervel Between
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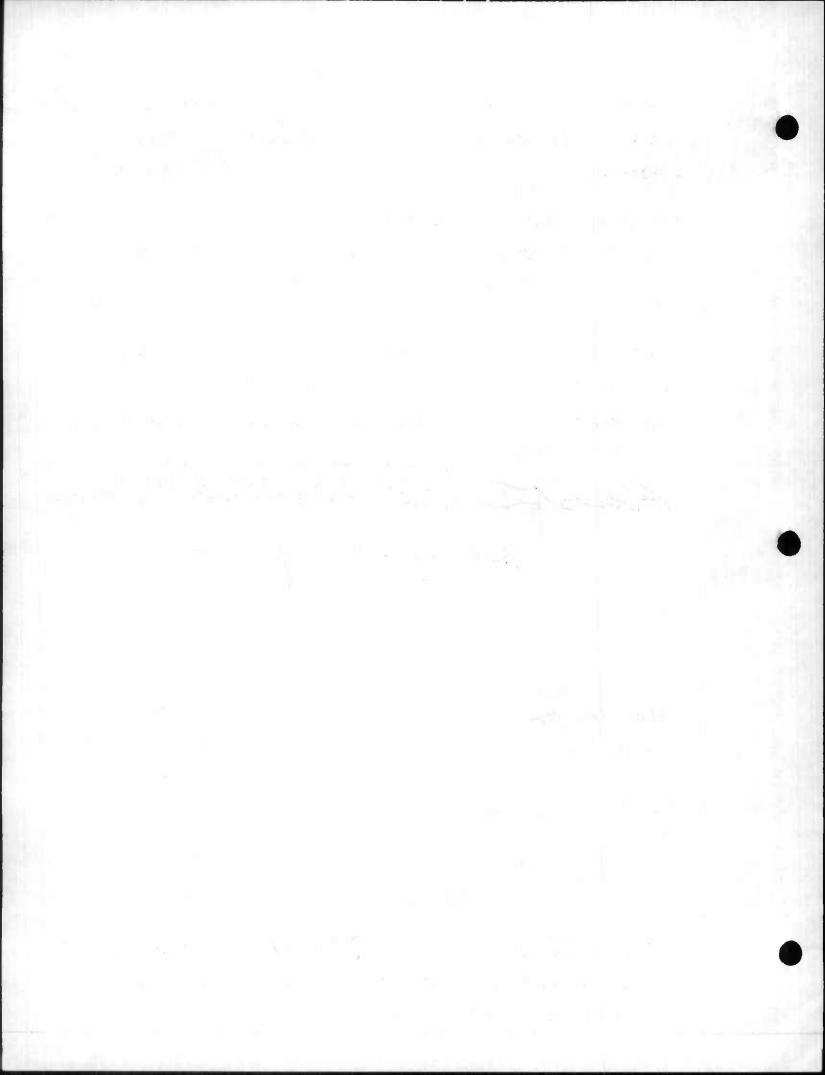
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State of Maryland / Department of Health and Mental Hygiene 8 06890

						Cei	tificate of	Death		Reg	. No.		
			1. Decedent's Name (First, Middle,	Lest)						e of Death		Vass	3. Time of Deeth
	Physic /Medi		SU-TAN	SHI	[H				FI	EBRUAF	RY 17,	1998	3:00PM
	Exami		4e. Fecility Neme (If not institution, g					4b. City, Town	VILLE			of Death	Y
	Funeral Director		5. Social Security Number 212-39-5272 Usuel Residence of Decedent	. Sex 7. Ag	ge (In yrs. lest 75	birthday) Yrs.	If Under 1 Yea Months Deys		Min. 8. De	e of Birth onth, Day, Y	1923	9. Birthp Coun TAIW	lace (State or Foreign try) AN
	land		10a. State 10b. County		10c, City, To	own or Lo	cation					1	0d. Inside City Limits
	he Mary 8a-f sh	Director	MARYLAND MONTGO	MERY	ROC	KVIL							1 Yes ZE No
	23a or 2	rai Dir	10e. Street end Number 12203 BRAXFIELD	COURT #15			10f. Zip Code	52			O.C-T		
21215-0020	filed within 72 hours after death with the Maryland Hygiene. Anatural', or Items 23a or 28a-1 show ther than "natural", or Items 23a or 28a-1 show ont, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U,S.		Nas Decedent of f Yes, specify Cu I □ Yes 2X No		n? (Specify Ye Puerto Rican,	es or No- etc.)		ce - Americ ck, White,	etc.
5-0	72 h netu	etec	15. Decedent's (Specify only highest of	Education	16	Se. Deced	lent's Usuai Occu	upation e during most o	f working	16	8b. Kind of B	usiness/Ind	lustry
121	within ene. than	Completed	Elementery/Secondery (0-12)	College (1-4or	5+)		kind of work done	ed)	· woming		0.777 17	01/5	
12	il Hygiene. other than		12TH			НО	MEMAKER	1			OWN H		
Maryland	b d la b	To Be	JUN SU	57)				AI	CHAN		aiden Suman	ne)	
lar			19e. informent's Neme/Reletionship	(Type, Print)			g Address (Stree						
	Health Health tem 27		STEVE SHIH-SON				BRAXFIE	ELD COU	RT #15	ROCK	/ILLE,	MARY	LAND
Baltimore,	0 0 -		20e. Method of Disposition 1 ☐ Burial 2X Cremation 3 4 ☐ Donetion 5 ☐ Other (Special Control of the Control		ceme	tery, cren	sition (Name of natory or other pl		Date		c. Location		
Balti	permit. Page Department of Important: If eny Injury or once.		21. Signature of Euneral Service Lic		ME.	D^{22}	NŽANSKÝ 70 ROCKV	-GOLDBE	RG MEMO	DRIAL	CHAPE	L INC	
	_		23a. Pert1. Enter the disease, or co shock, or heart feilure. List on	mplications that caused	the death. D								Approximate Interval Between
x 68760,	eath certificate be axecuted attending physician and attending physician and for use as the bunal-transit	Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Lest	a. Acul	Due to (or as	a conseq	uence of):	infi	are Te				
Box	ath c	ian		u							_		
P.O.	ras that the death ce igned by the attendir be datached for use	y Physician/	Part II. Other significent conditions Hyvertensi		ut not resulting	In the ur	nderlying cause g	iven In Part i.	23		2 No		the cause of death?
of Vital Records,	aw requiras is been sign 2 should be	Completed by	- Hyertensi	3					24	a. Was en		ave	ore eutopsy findings eilebie prior to mpletion of cause deeth?
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ita	ician: The cartificata rector, pag	Be (25. Was case referred to medical					26. Piace o	f Death (Chec	k only one)			
t <	5 00	To	examiner? X 1 Ves 2 No	Hospitel: 1 ☐ inpatie	ent 2 ER/	Outpatien	1 3 DOA O	ther: 4 Nurs	ing Home 5	Residen	ce 8 Oth	ner (Specif	()
o uo	ling After		27. Menner of Deeth 1 ☐ Naturai 5 ☐ Pending 2 ☐ Accident investiget	28e. Date of inju (Month, Da	y Year) 28b	Time of Injury	28c. inju W		28d. De	_	injury occur		
Division		Certification:	3 Suicide 6 Could not determine	be an Pines of lei	ury - At home, c. (Specify)	farm, stre	et, fectory, office			cation (Stre		ber or Rure	l Route Number,
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	-	M	29b. Signature end title of certifier)			29c. Licer	k 70	7		i. Dete signe		
,	10		30. Neme end address of person wh	•			,	0101			EBRUAR		1770
			TUNG-PI LEE, M			1 DRI	VE-SILV	ER SPRI	NG, MA	RYLANI	D 2090	1	
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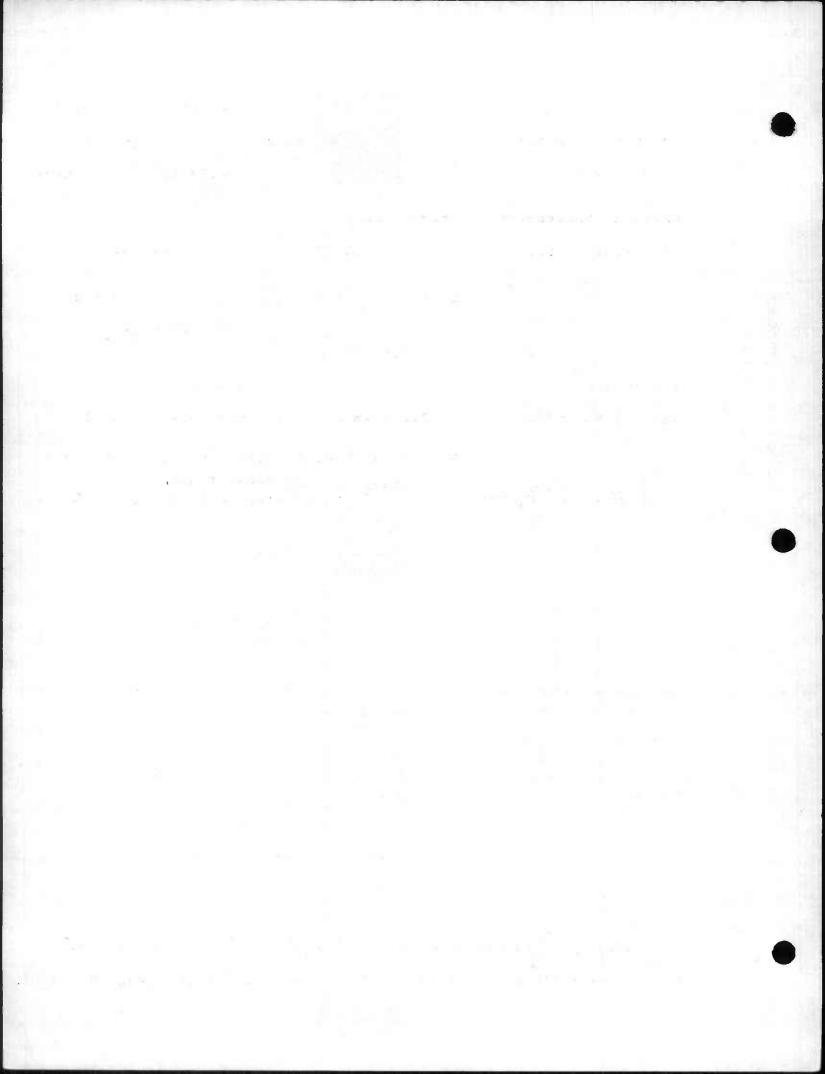
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 2 05001

			,	Ce	ertificate of	Death	Re	g. No.	00091	
Physi	oian	1. Decedent'a Name (First, Middle, Last)				2. Dete of Deeth	Day 1	3. Time of	Death
/Med		JULIAN S	MOn				Februar	ry 8,19	998 3:50	Opm
Exam	iner	4e. Facility Name (If not Institution, give				4b. City, Town, or L		4c. County of		
	М	Suburban Hospit			If Under 1 Yeer	Bethesd		Montge	-	
Funera Directo		130 24 3737	7. Age (In y) ☐ M 2□ F 6 5	rs. last birthday 5 Yrs.	Months Deys	Hours Min.	8. Date of Birth (Month, Day, Feb. 12	Year) , 1932	9. Birthplaca (State or Country) New Jers	Foreign sey
and w		Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside Cit	v Limits
Mary 4 ah	ō	Maryland Montgo	mery Ch	hevy C	hase				17 Yes	
with the 3e or 28e	I Direc	10e. Street and Number 110 Primrose St			10f. Zip Code 2081	5	10	g. Citizen of Wi		
poemit. Pages 1 and 2 should be lifed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Executes must be notified at	by Funeral Director	11. Maritel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	orea 13.	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispenic Origin? (Spean, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Black	-American Indian, White, etc. White	
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d within 72 hours af giene. or then "netural", or	Completed	Elementery/Secondary (0-12)	College (1-4or 5+)		essor	during most of work	ing (sity of ryland	
off-	Be	17. Father's Neme (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
Went Went rked	10	Philip Simon				Mae Goo	dstein			
ind 2 should be file sith and Mental Hy 27 Is marked other		19a. Informant's Name/Relationship (7) Rita J. Simon/V			-	e St. Ch				
wemit. Pages 1 a populari Reminy Injury or other		20e. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donetion 5 □ Other (Specify)			position (Name of ematory or other place vid Mdm				Church,	VA
permit. Departminents any inju		21 Signature of Funerel Service Licens		I	22. Name and Addre	ess of Fecility rson Fun	eral Ho	omes		
_		23a. Part1. Enter the disease, or compl ahock, or heart failure. List only o	ications that caused the de			son Blvd		-	VA 2220	
The law requires that the death certificate be executed with the death certificate be executed at the base been signed by the attending physician and position and position of the position of	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to	o (or as a conse	equence of):	nfericles	71			
ath certifica	an/Med	C.	i							
ires that the death cer signed by the attendir d be detached for use	Physician/Medical	Part II. Other significant conditions con Past Sistem			underlying cause gi		23b. Did tot		ribute to the cause o	
he law requires the has been signe	should be d	00					24a. Was an perform	eutopsy ed?	24b. Were autopsy fit available prior to completion of ca of death?	ndings) ause
The interpretation							1 ☐ Yes	s 2 1 No	1 🗆 Yes 2 🗆 I	No
slefan: Ti certificate lirector, pe	Be (25. Wes case referred to medical examiner?				28. Place of Deat	h (Check only one)		
nysic lis ce	To	1 Yes 20 No	lospital: 1 Inpatient 2	ER/Outpatle	ent 3 DOA	her: 4 Nursing Ho	me 5 Resider	nca 8 Other	(Specify)	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death 1 Natural 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spe	t home, farm, s	M 1	ryat rk?]Yes 2□No	28d. Describe hor 28f. Location (Str. City or Town,	eet and Number	d r or Rural Route Numb	ber,
is af		29a. Cartifier 19 Certifying Phys	sician: To the best of my k	nowledge, dea	th occurred et the ti	me, dete end placa,	and due to the ca	use(s) and man	ner as stated.	
Hosp 14 hou Funer taly fil	Ca	(Uneck only 2] Medical Exami	ner: On the basis of exami	HIGHOLI SHIWOL II	nvestigation, in my o	spinion, death occur	ed at the time, de			9
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At completaly filled in by the fu	Medical	(Check only one) 20 Medical Examione) 29b. Signature and title of certifier.	ner: On the basis of examinend manner stated.	raghe	29c. Licen		29		(Month, Day, Year)	
To the Hospi within 24 hour To the Funer completely file	Medica	one) 2 Medical Exami	end manner stated. Description of the basis of examination and manner stated.	To he	29c. Licen:	se number 0/63/	29	d. Date aigned	(Month, Day, Year)	

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) ROSE 2. Dete of Deeth FEB onth 4e. Facility Neme (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death ewe ua OK 5. Sociel Security Number ii Under 1 Yeer il Under 24 Hrs. 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) 9. Birthple Days Hours 1 ☐ M 2 F 82 Yrs. 111-14-0543 JUNE 6, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND CHARLES WALDORF 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 10372 JEWEL COURT 20601 USA 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No ill Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced WHITE Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) **NURSE-RN HEALTH CARE** 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JOSEPH F. O'DONNELL **ELLA** BOYLE 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM J. STEEGER / HUSBAND 10372 JEWEL COURT WALDORF, MARYLAND 20601 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removel Irom State 4 ☐ Donetion 5 ☐ Other (Specify) **HUNTT CREMATORY** 2-21-1998 WALDORF, MARYLAND 22. Name end Address of Facility THE HUNTT FUNERAL HOME, INC. 21. Signature of Juneral Service Licensee SHANNON W. RAMIREZ MOD M00798 P.O. BOX 156 WALDORF, MARYLAND 20604 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth CAMCER immediate Cause (Finel PAYCREASE OF disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence oi): 23b. Did tobacco use contributa to the cause of death? 3 Probably Whitnown 1 Yas 2 No 24a. Was en eutopsy performed? 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1 Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

thet the death certificate be axecuted

P.O. Box 68760.

Records,

Division of Vital

Physician /Medical

Examiner

10e. Stete

Funeral

Director

28a-f show

6 items 23a

6

"natural",

Director

Funeral

à

Completed

traumatic event, the Medical Exansiner must be notified

filed within 72 hours eftar Hygiena.

permit. Pages 1 end 2 should be filed withit Department of Health and Mental Hygiena. Important: If Item 27 is marked other then any Injury or other traumetre.

Baltimore, Maryland 21215-0020

the Maryland

attending physician and for use es the bunal-transit Physician/Medical by Completed page 2 s To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this cartifica completaly filled in by the funaral director. Be 2 Certification:

signed by t

cartificata

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical exeminer?

1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 6 Could not be

28e. Plece of Injury - At home, larm, street, lactory, office building, etc. (Specify)

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier

1 Yes 2

27. Menger of Death

Neturel

2 Accident 3 Suicide

4 Homicide

31. Dete filed (Month

29a. Certifier

29c. License number

28c. Injury et Work?

1 Yes

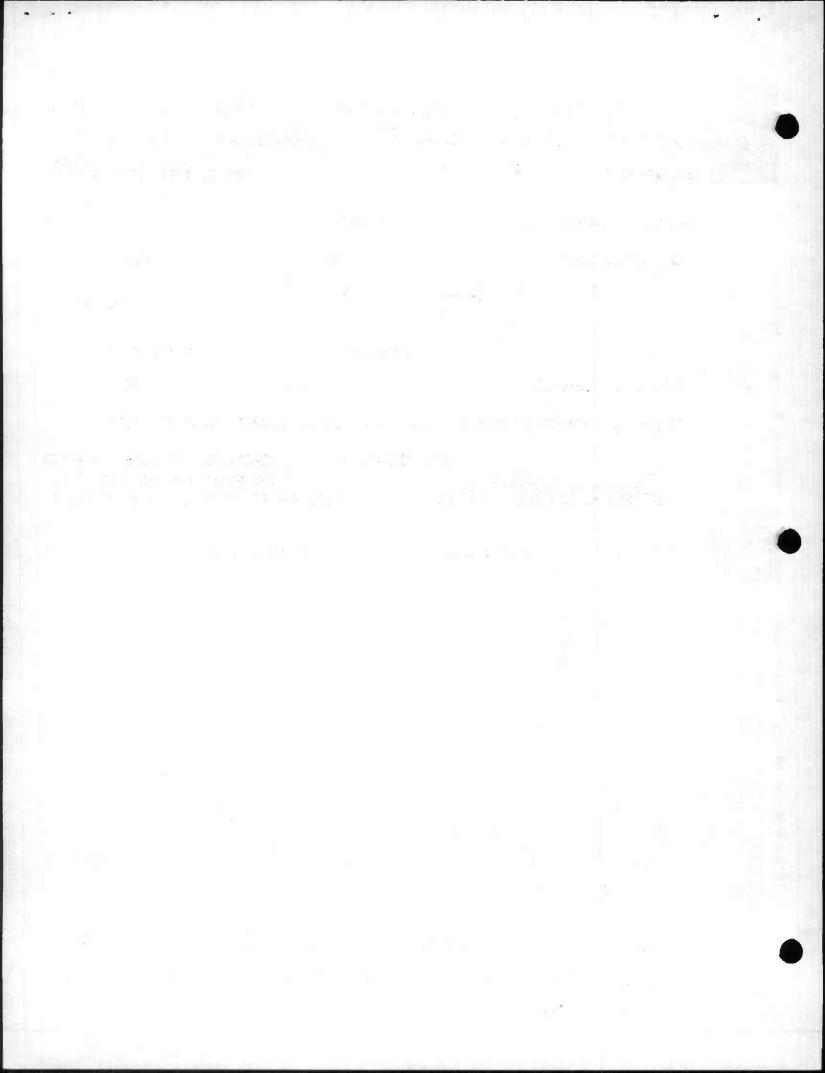
29d. Dete signed (Month, Dev. Year)

30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

State Registrar

Medicai

32. Registrer's Signature

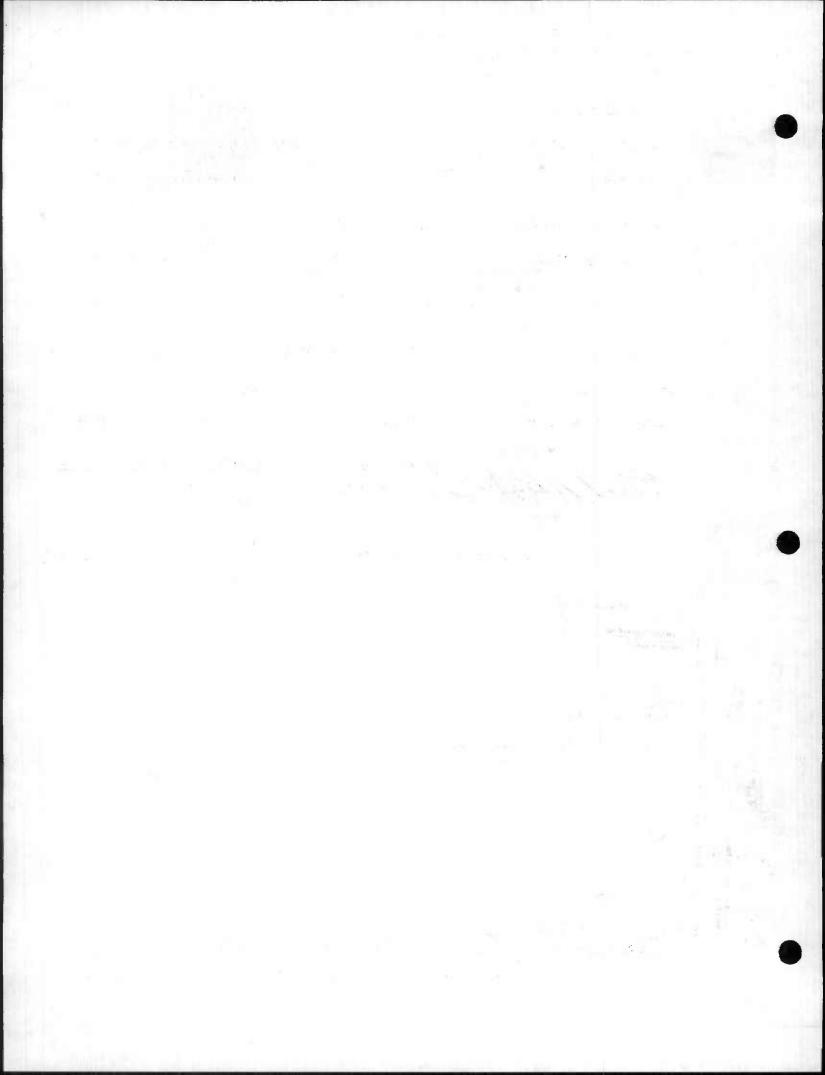


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		1 Decedentia Name (First Add # 1		(Certificate of	of Death		leg. No.		
Physic	ian	1. Decedent's Name (First, Middle, Li					2. Date of Dea Month Februar		ά β ar	3. Time of Death 20:10
/Medi		Joseph Alvin Swa				4b. City, Town, or		y 13 13		20.10
Exami	ner	4e. Fecility Name (If not institution, give street and number)								
Francis		St. Mary's Hospi 5. Social Security Number 6.		n yrs. last birth	day) If Under 1 Ye	Leonard par If Under 24 Hrs			Mary	
Funeral Director			1 ■ M 2□ F				s Hours Min. B. Date of Birth (Month, Day, Year) December 22, 1917 Ohio		place (Stete or Foreigntry)	
Maryland f show	ust be notified at ust be notified at all Director	10a. State 10b. County		c. City, Town					1	0d. Inside City Limit
the 1		Maryland St. Ma	ry's	Lexir	gton Park			Og. Citizen of V	Mhat Cour	to/2
with we	ō							United States		•
deeth 22	or items	311 Kearsarge Pla	12. Was Decedent Eve	r In U.S.	206		Specify Yes or No-			an Indian,
Z IZ I D-UUZU d within 72 hours effer o giene. ir than "natural", or fren ir the Medical Exeminer		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ■ Yes 2 □ No		If Yes, specify C	of Hispanic Origin? (Stuban, Mexicen, Puerl No <i>Specify:</i>	o Rican, etc.)	Specify Specify	k, White,	etc.
72 hours		15. Decedent's E	ducation	Year or Dates:1938–1960		ccupation		16b. Kind of Business/Industry		dustry
9 .	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	completed) (Give kind of work of life, DO NOT use r		done during most of working retired)				,
filed within Hygiene.	mo:	12	Commission		Commissioned Officer		U.S. N		lavy Defense	
	Bec	17. Fether's Name (First, Middle, Las				18. Mother's Name (First, Middl		ie, Maiden Surname)		
should be and Mentel marked o	To	John Alvin Swan				Letha I	Bragg			
Maryland d 2 should be file lith and Mentel Hy 77 is marked oth traumatic event		19a. Informant's Name/Relationship	Type, Print)	19b. I	Mailing Address (Str	eet and Number or Ru		r, City or Town.	State, Zip	Code)
		Constance J. Stev	enson	424	Severnsi	de Drive,	Severna	Park, I	MD 21	146
of Heel		20a. Method of Disposition		20b. Place of E	Disposition (Name of crematory or other)	place)	Date	20c. Locetion -	City or To	wn, State
Pag ent ry c		1 ☐ Burial 2 ☐ Cremation 3 ■ 4 ☐ Donation 5 ☐ Other (Speci		CONT. NO.	view Cemetery 2/21/98 Barnesville,			01.1		
Delling permit. Pa Depertmen important: any injury		21. Signature Ameral Service Liga	1 / Deep	FSLV.	22. Name end Ad		721/98	Barnesv	iiie,	_Un10
Depe impo any i		Valued IV	any	100052	Brinsfie	ld Funera	l Home, I	P.A.		
		23a, Part1. Enter the disease, or corr			22955 Ho	ollywood Ro	oad, Leor	nardtow	a, MD	20650 Approximate
Physician		shock, or heart failure. List only one cause on each line.								Interval Between Onset end Deeth
/Medical		Immediate Cause (Final	· Jan	Preumonia				10		. /
Examiner		disease or condition resulting in death)								week
	ě		Due to (or as a consequence of):							
Insit	Examiner		b. —		7				1	
axec n and el-tra	Exa	Sequentially list conditions, if any, leading to immediate	Due	to (or as a co	nsequence of):				1	
ificete be executed physician and st the buriel-transit	cal	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	c	Due to (or es e consequence of):					-	
tificet ng phy es the	edical	resulting In death) Last	Due	to (or es e co	nsequence or):					
ath certi	2		d							
	by Physician/M	Don't Other design					1 22 200			
at the d	ys	Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause								
that the	y P	Dementra				1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkno				
iaw requires that the de as been signed by the c 2 should be deteched	q p	0/ >		7			24a. Was a	n autopsy	24b. W	ere autopsy findings
S Pe Pe Pe	ete	Shy Drager Syndran					performed? evailable prior completion of completion		ailable prior to mpletion of cause	
D & 85 C	Completed	/ /					of de		death?	
							1 🗆 Yı	es 2 200	10	Yes 2 No
Physician: T This certificat ral director, p	Be	25. Was cese referred to medicel examiner?	Heavital.				ath (Check only on	10)		
Physic this ai dir	P	1 Yes 2 No	Hospital: Inpatient	2 ER/Outp	atient 3 DOA		lome 5 Reside			y)
f fe je	on:	27. Manner of Death 1 → atural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Tir lnji	iry V	njury at Vork?	28d. Describe h	ow injury occurr	red	
or Attending I or Attending I or Attending I office death. Director: Affer din by the funer	tal or Attending P rs efter death. al Director: After ti led in by the funera Certification:	2 Accident investigatio			M 1 Yes 2 No					
or Attendi effer death Director: A	Ę	3 Suicide 6 Could not be determined	280. Flace of injury -	. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Si City or Town	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
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To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the it	within 24 hours effer deat To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one) 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To the To the Com	Σ	29b. Signeture end title of confiner	/ 1		29c. Lice	ense number	2	9d. Date signed	d (Month,	Day, Year)
		Dell	12	1	and ?	252	30	2/1	17/	98
		30. Name and address of person who Dr. DAVID ALLEN	St. MARY S	(Item 23a) (To MEDIC	ype, Print) AL ASSOCI.	ATES, WILE	EWOOD CI	R. CALI	FORN	IA, MD
Sta	ite	31. Dete filed (Month, Day, Year)	32. Registrar's	Signature				-		
Registr		FEB 18 1998	Julia Davide	ox-Randa	Uį					
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DHMH 16 Rev 6/95

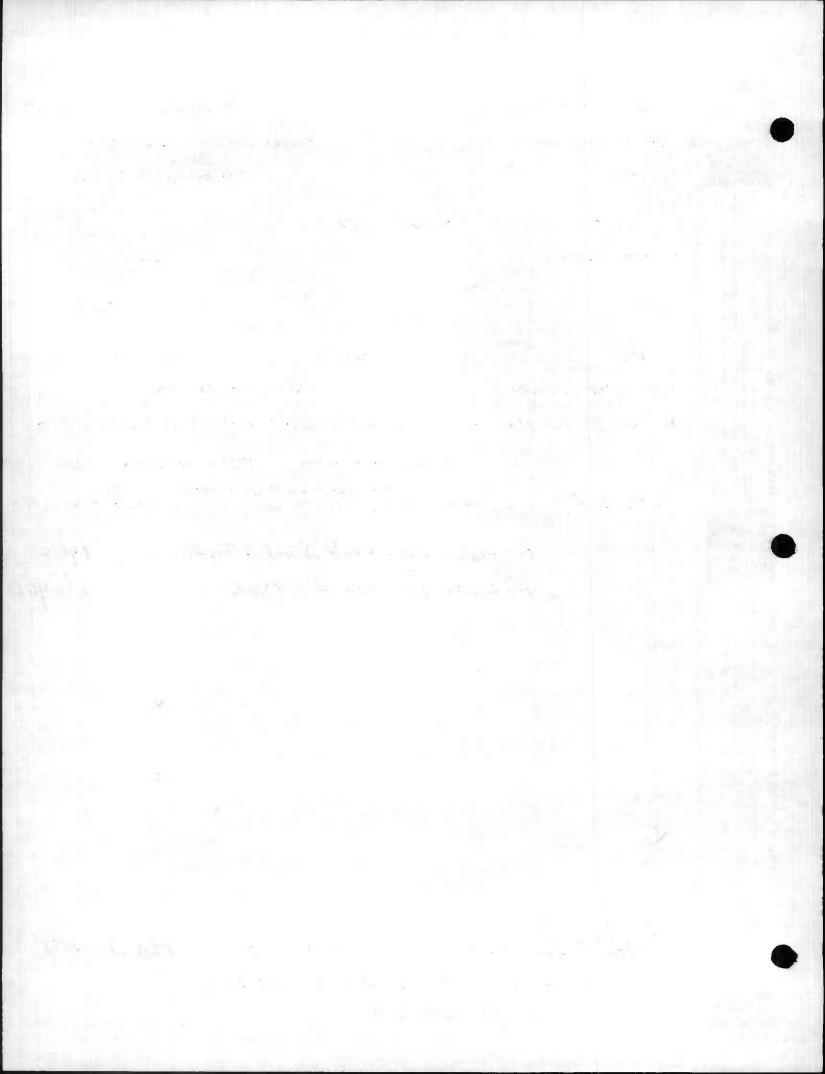
NAME: JOSEPH SWANN



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Robbie Dean Seekford February 21, 1998 2:40 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** 30175 Dudley Road Mechanicsville St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplaca (Stata or Foraign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Funeral 1 ☐ M 2 🛛 F Yrs. Director 230-56-3434 54 November 13, 1943 Virginia Usual Residence of Deceden with the Maryland pernit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Wed cal Examinet must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Directo Maryland St. Mary's Mechanicsville 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Coda 30175 Dudley Road 20659 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, Whita, atc. 11. Merital Stetus 1 Yas 2 No If Yes, Give Yeer or Detes: 1 Navar Marriad 2 Married 1 Yas 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 11th Homemaker Own Home 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Sumame) Gilbert Warren Campbell Daisy Bell Lawhorne 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William C. Seekford/Spouse 30175 Dudley Road Mechanicsville, Maryland 20659 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) 2/25/98 Leonardtown, Maryland Charles Memorial Gardens 21. Signeture of Funerel Servica Licansee 22. Name end Address of Facility Mattingley-Gardiner Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter shock, or heart failure. List only one cause on each line. P.O. Box 270, Leonardtown, Maryland 20650 inter tha mode of dying, such as cardiec or respiratory arest. Approximata Intervel Between Onset and Death **Physician** Immediate Ceuse (Final diseasa or condition resulting in deeth) /Medical Examiner Examiner physician end the burial-transit The law requires that the death certificate be asscuted Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initieted events rasulting in daeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequance of): 88 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings avellable prior to Completed completion of causa of death? certificata has b lirector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was casa raferred to medical examiner? Be 26. Plece of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🎇 Rasidance 6 ☐ Other (Specify) 2 1 Yas 2 No this funeral 27. Mangar of Daeth
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: After 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, Stata) 3 ☐ Suicide 2 4 Homicida 24 hours 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at tha time, data end piece, end due to tha ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, dete end place, end dua to tha causa(s) end menner stated. edical 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of corp. 29c. License number 29d. Data signed (Month, Dey, Year) velu 30. Name and eddress of person who completed cause of death (Itam 23a) (Type, Print) Mechanicsville, Maryland 20659 John W. Roache, MD 31. Date filed (Month, Day, Yaar) 32. Registrer's Signeture FEB 24 1998 This Davidson Randall

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

				Ce	ertificate o	f Death	R	eg. No. 98	06895	
Physici /Medio			UTH SLAD	WGHTER			2. Deta of Dee Month FEBRUAR	Day / /7 /	3. Time of Death 9: 40 A	
Examiner _c Funeral Director		4a. Facility Nama (If not institution, give Completed of the Complete of the C	LAND MEDIC	(In yrs. last birthda)	// If Undar 1 Yas Months Day	BALTIN ar If Under 24 Hr	s. 8. Data of Birth	N Year)	9. Birthplaca (Stata or Fore	
the Maryland 28a-f show nortfed at	to	10a. Stata 10b. County MD TALB		10c. City, Town or L					10d. Inside City Lim	
within 72 hours efter death with ene. than "natural", or items 23s or the Med cal Exerciter must be nompleted by Funeral Dispense of the property of the New Young the name of the New Young the name of the New Young the name of the New Young the name of the New Young t	al Director	10e. Street and Number 820 N. WASHIN			10f. Zip Coda 2160		1	0g. Citizan of W		
	by	11. Marital Status 1 ☐ Nevar Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Dacedant Ev Armad Forcas? 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas:	var in U,S. 13.	. Was Dacedent of If Yes, specify Cu 1 ☐ Yas 2 ☑ No		Specify Yes or No- rto Rican, atc.)	Btac	a - Amarican Indian, k, Whita, etc. BLACK	
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should Ind Meni	d Mental d marked or matic eve	ANDREW POW 19a. Informant's Name/Ralationship (7)	ELL Ima Printi	10b Mail	ling Addrage (Stro		RY VIRG: Rural Routa Number			
1 and 2 sho Haalth end em 27 is me		BETTY CROMWELL			-				N, MD. 21601	
00		20a. Method of Disposition 3 Buriat 2 Cramation 3 Ramoval from State 4 Donation 5 Othar (Spacify) 20b. Place of Disposition (Nama of cematary, cramatory or other placa) RICHARDS MEM. PARK 2/21/98 EASTON, MD								
permit. Pag Department Important: It any Injury o		21. Signature of Funaral Service Licensaa 22. Nama and Address of Fecility DASHIELL FUNERAL SERVICES 319 E. DOVER ST. EASTON, MD. 21601								
the deeth certificate be associed by the ettending physician and sched for use as the buriel-transit	/Medical Examiner	disease or condition resulting in death) Saquentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last	. Cor	ua to (or es a conse ONARY ua to (or as a conse PERTEM a to (or as a consa	ARTER	Ly Disi	EASE		10 day 15 year 20 year	
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this ral di	ation: To B	axamIner? 1 Yas 2 No 27. Menner of Death 1 Naturel 5 Panding 2 Accidant Invastigation	Hospital: 1 Inpatient 28a. Data of Injury (Month, Dey Y	2 ER/Outpatie	of 28c. Inj	ther: 4 Nursing	Homa 5 ☐ Raside	nce 6 DOtha		
	Certification:	3 Suicida 6 Could not be determined	building, etc. ((Spacify)	straat, factory, offica 28f. Location (Street and Number or Rural Route Number, City or Town, Stata)					
4 hour	edicai	29a. Certifiar Check only one) Cartifying Phy 2 Medical Exami	sician: To the best of n inar: On the basis of ax end manner state	camination and/or in	th occurred at the invastigation, in my	tima, date and plac opinion, daath occ	a, and due to tha ce urred at the time, da	eusa(s) and mar ate end piece, a	nnar as stated. nd due to tha cause(s)	
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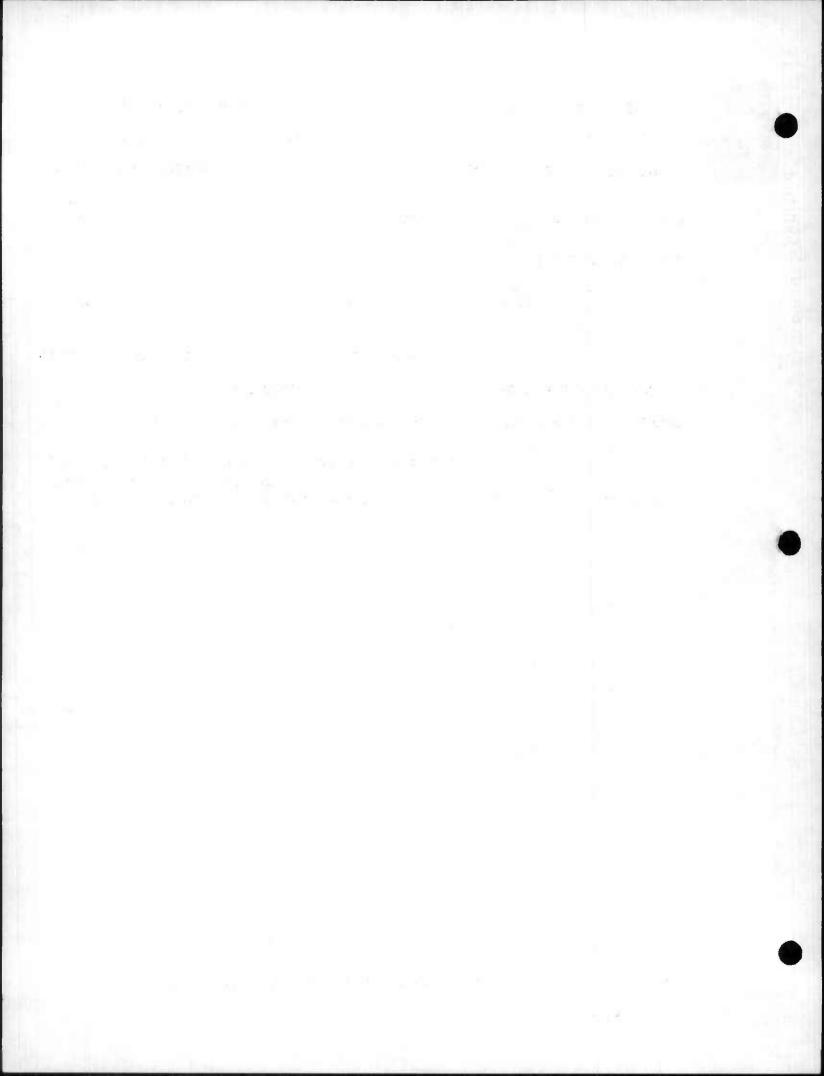
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Robert Scanland

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 14 1998 3:30P ROBERT BOYD **SCANLAND** /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Talbot If Under 24 Hrs. 5. Social Security Number if Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth APR. 26, 1914 9. Birthplace (State or Foreign **Funeral** Months Days **№** M 2 F Hours 83 CALTFORNIA Yrs. Director 214-03-2833 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show adical Examiner must be notified at 10d. Inside City Limits Director MARYLAND CAROLINE DENTON Yes 2□ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 COLONIAL DRIVE by Funeral 21629 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck. White, etc. 1 Tyres 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2√2 No 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed th end Mental Hygiena.

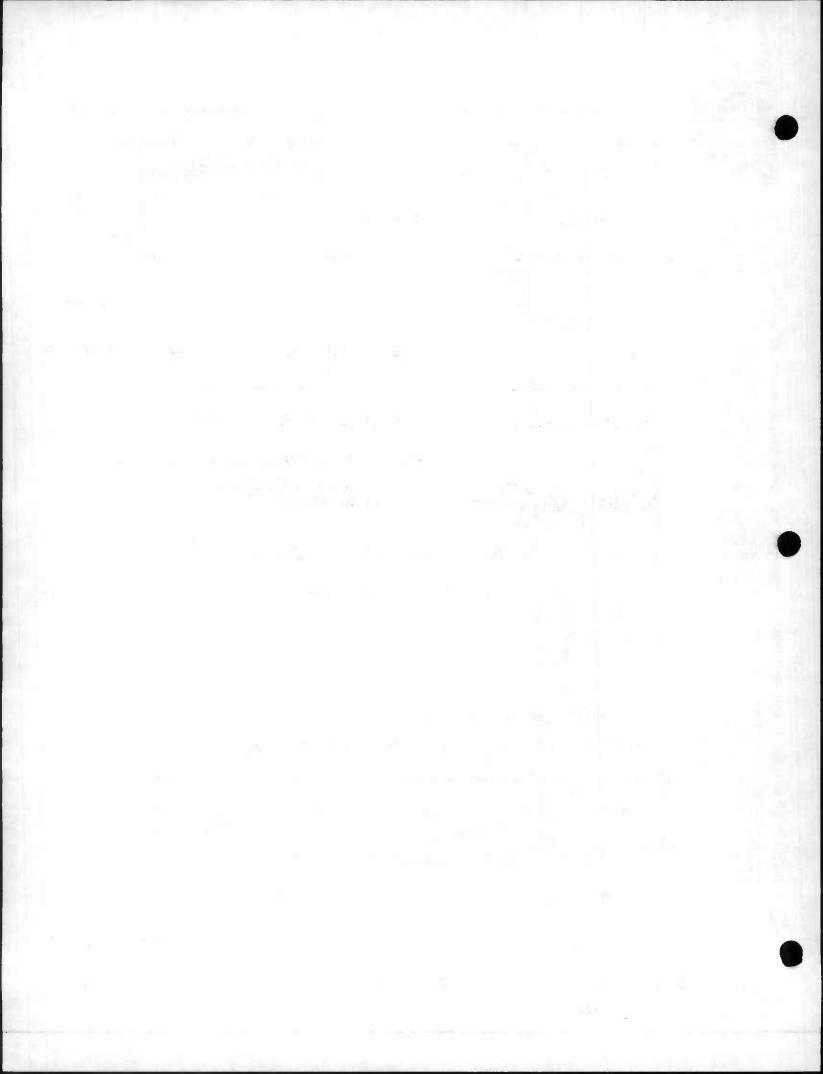
7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 EXECUTIVE INTERNATIONAL SALES Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Peges 1 and 2 should be facent of Health end Mental Hint: If Itam 27 is marked of FRANCIS WORTH SCANLAND MILDRED BOYD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end Depertment of Health Important: If Itam 27 any Injury or other tr. once. ROBERT B. SCANLAND, JR.-SON P.O. BOX 59 ROYAL OAK, MD. 21662 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) CHESTER, MD. 21619 CHES. CREMATION CTR. 2-15-98 22. Name and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM 21. Signature of Funerel Service Licensee Joseph M. Ostrowsk. 200 S. HARRISON ST. EASTON, MD. 21601 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Physician /Medicai Immediete Ceuse (Final PNEWMONIA disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner CEREBROVASCULAR ACCIDENT The law requires that the death certificate be axecuted burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last pul physician the buria HEARTFAILURG P.O. Box 68760, ON GESTIVE Physician/Medical use Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate nes been signed by page 2 should be detact 1 Yas 2 No 3 Probably ₱ Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 2 1 No certificate Division of Vital or Attending Physician: director, Be 25. Wes cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 28 No 1 Lopatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Affer 1 Maturel 5 Pending 1 Tes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completaly filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated. Medical 2 Madicel Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) 109 S. COMMERCE ST. CENTREVILLE, MD. 21617 ERIC F. CIGANEK, M.D. 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signature State Luka Davidson FEB 1 7 1998 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



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	the basis of examination manner stated.	tion and/or inve	estigation, in my o	pinion, death occu	irred at the time,	date and place,	and due to t	ne cause(s)
29b. Signature and title of certifier			29c. Licens			29d. Date signed		
Brown			126	907		FEBRUARY	17	, 1998

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q

## Facility Name of nor Institution, give street and number) Social Security Number Social S		ian	1. Decedent's Name (First, M			1			2. Date of Death	g. No.	Year	3. Time of Dee
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4 Diseases of Southern Species Leaving 12-Feb-98 Cumberland, Maryland 22-Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22a. Papt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 22a. Papt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 22b. Papt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 22c. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Name and address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 22c. Durst Funeral Hom	Hear other				20b. i	Place of Dispo	sition (Name of	T				
23a. Past Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bet Onset and Line List only one cause on each line. Due to (or as a consequence of):	ant: If i				Stata				2-Feb-98 C	umberla	nd, N	Maryland
Medical amiliner Medical ami	Dependiment any inj		21. Signature of Funeral Serv	ica Licenza	ret				ost Ave., Fr	ostburg, i	MD 2	1532
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cant Part II. Other significant conditions contribute to the cause of th	physician end s the burial-transit		triat initiated events	c								
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25. Was case referred to medical examiner? 1		sicia	Part II. Other significant cond	litions contributing to d	leath but not res	ulting in the u	nderlying cause giv	en In Part I.	23b. Did tob	acco use cont	ributa to	the cause of de
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6 D21244 FEBRUARY /2, 1998	s been signed by the ettandin 2 should be deteched for usa	Be Completed by	25. Was case referred to med	ical	15mmz Failer	e tis			24a. Was an performe	2/25No	con of d	ilable prior to apletion of cause eath?
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The same of bottom was combined again from Early (11ha), 1 mill)	 within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be deteched for use 	edical Certification: To Be Completed by	25. Was case referred to med examiner? 1 Yes 2 No 27. Manner of Death 1 Accident 3 Suicida 6 Cou 4 Homicide 29a. Certifier 1 Certific (Check only one)	Hospital: Hospital: Hospital: 28a. Date (Mor stigation lid not be ermined 28e. Plec build lying Physician: To the tal Examiner: On the b	Anpatient 2 Cooling of Injury of Injury th, Day Year) e of Injury - At h ling, etc. (Special be best of my knowasis of axamina	ER/Outpatier 28b. Time of injury ome, farm, str	f 28c. Injur Wor M 1	ar: 4 Nursing Ho y et k? Yes 2 No ne, date and plece, pinion, daath occurr a number	24a. Was an performed a perfor	ca 8 Other vinjury occurre set and Number State) use(s) and man e and place, ar	ava com of d 1 (Specify, d r or Rural ner as stand due to (Month, L	ilable prior to no cause eath? Yes 2 No Route Number, ated. the cause(s)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** DORIS V. STERLING 20 1998 700 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 8. Dete of Birth (Month, Dey, Year) Nov. 9, 1919 If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Months Deys Min Hours 78 214-03-5811 Yrs **Director** Pennsylvania Usuei Residence of Decedent the Maryland 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or items 23a or 28a-f show treumatic event, tra Medical Examinat must be mutilial at Maryland 1XYes 2□No Director Somerset Crisfield 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4 Standard Ave. 21817 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Stetus 14. Rece - American Indien, Bleck, White, etc. hours efter 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give Yeer or Dates: Specify: White Š 3 M Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hyglena. Elementary/Secondery (0-12) Coilege (1-4or 5+) Food Market Cashier 11 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be 12 should be fi and Mantal H Charles M. Warwick Laura Elizabeth Howeth 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 a Depertment of Health ar Important: If Item 27 le. Herbert J. Sterling (son) 4 Standard Ave. - Crisfield, MD 21817 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete Burial 2 ☐ Cremetion 3 ☐ Removel from State Crisfield Cemetery 2/23/98 Crisfield, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licansed Robert H. Bradshaw Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Rosp. Distress syn' Physician/Medical Examiner Acute physician and the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Last Due to (or es e consequenca of) wmonam EURU Box 68760. Due to (or es e consequence of): 50 MI usa 5 Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. eun 23b. Did tobacco use contribute to the cause of death? signed by t au lur 1 Yee 2 No 3 Probably & Unknown by 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peen : page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate director. Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To (☐Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28h Time of 28c. Injury et Work? 28d. Describe how injury occurred Aftar 1 Neturel
2 Accident or Attending 5 Pending 1 ☐ Yes 2 ☐ No Investigation after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide hin 24 hours at the Funeral D mplataly filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and magner steted. 29a. Certifier Medicai (Check only one) within 2 To the I 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 2 2 6 98 25036 SHORE . SALISBURY-M.D. 21801. 30, Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 614 EASTERN H.R. HEDA 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State FEB 25 Registrar

DHMH 16 Rev 6/95

214-03-581

Sterling

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Charles H. Warvick

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4 Standard Ave. - Orietteld, ab 21 m

Crist Main Cened by 2723 Tel 121 Miles

Stadunaw & Sons Funeral Incom 306 N. main St. - Sciaffinia.

white would say, open a cities

			Cert	tifica	te of	Death			Reg. No.	30) U	0700
1. Decedent's Neme (First, Middle, Las	st)							2. Date of D			Year	3. Time of Deeth
Anna Troiano								Febru			1998	11:00 PM
4a Facility Neme (If not institution, give	e street end number)					4b. City, To	wn, or L	ocation of Dea	th 4c.	County	of Deeth	
Care Matrix Heal	th Care Co	enter						Spring	N	lon t	gomen	у
5. Social Security Number 6. S	ex 7. Ag	e (In yrs. lest b		If Under	or 1 Year Deys	If Under Hours	24 Hrs. Min.	8. Dete of Bi (Month, D	rth ey, Year)		9. Birthp Coun	lece (Stete or Foreign try)
218-54-8613	DIM 201	98	Yrs.					May 30	, 189	9	Ita]	
Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, Tov	wn or Loc	ation							1	Od. Inside City Limits
Manusland Dudman	Coomooo	Belt										1 ☐ Yes 2X No
Maryland Prince 10e. Street and Number	Georges	Delt	SVII	T	ip Code				10a. Citi	zen of	Whet Coun	trv?
3613 Chase Ter					705				US			
11. Marital Status	12. Wes Decedent	Ever in U,S.	13. W	as Dec	edent of	Hispenic Or	igin? (Sı	pecify Yes or N			e - Americ	en Indian,
1 ☐ Never Merried 2 ☐ Merried	Armed Forces? 1 ☐ Yes 2 [X]	No	14	Yes, sp	ecify Cub	en, Mexice	n, Puert	Rican, etc.)			ck, White,	etc.
3 ₩Widowed 4 □ Divorced	If Yes, Give Yeer or Dates:		1	⊔ Yes	2 X No	Specify.				Specif	v: V	Vhite
15. Decedent's Ed (Specify only highest gra		188	Decede	ent's Usi	uel Occu	petion during mos	t of war	kina	16b. Kl	nd of B	usiness/înc	lustry
Elementery/Secondery (0-12)	College (1-4or 5	i+)	life. D	O NOT	use retire	ed)		9				
6			Hom	emak	cer	1					Home	
17. Fether's Neme (First, Middle, Last)								ne (First, Middle		Sumer	ne)	
Vincent DeLuca						-		na Mari				
19a. Informent's Name/Reletionship (19						ral Route Numi			, State, Zip	Code)
Mary Ford/Daught	er	20b. Plece				ers Lr	1, B	owie, M	1		- City or To	um State
20a. Method of Disposition 1	Removel from Stete	cemete	ery, crem	etory or	other ple		1					
4 Donation 5 Other (Specify		Ced				etery	1	Feb 18			ind, N	
21. Signeture of Funeral Service Licen	ISBB	0.0						nes-Rin				
Illang.	Wonne	le	11	800	New	Hamps	shir	e Ave,	SILVE	er	pring	g, MD 20904
23a. Pert1. Enter the disease, or comp shock, or heert feilure. List only	plicetions thet ceused one ceuse on eech li	the death. Do	not ente	r the mo	de of dy	ing, such es	cerdiac	or respiretory	errest,			Approximete Intervel Between
											i	Onset end Deeth
Immediete Ceuse (Finel disease or condition resulting in deeth)	Θ	Pneumon	ia								- (Over 1 Weel
resulting in destiny		Due to (or es e										
	b	Congest	ive	Hear	rt Fa	ailure	2				1	
Sequentially list conditions, if eny, leeding to immediate		Due to (or es e	consequ	ence of):						i	
Ceuse (Disease or Injury	C										1	
thet initiated events resulting in death) Lest		Due to (or as a	consequ	ence of):							
	d											
D. A.H. Ohb. and an effect of the control of the co			1- 44	4 4 4 -		to a la Bard		anh Die	l tabasas		and office of the state of the	the saves of death?
Part II. Other significant conditions of	ontributing to death b	ut not resulting	in the un	aenying	ceuse g	ven in Per	1.			_		the causa of death?
									Yes 2	X) No	0	abiy 4 dikilowii
									s en eutop	osy	24b. W	ere autopsy findings
								per	ormed?		co	mpletion of ceuse death?
								10	Yes 2	EF No	10	Yes 2 No
25. Wes case referred to medical				_		26 Plea	e of Des	ith (Check only		No.		
examiner? 1 ☐ Yes 2 ◯ No	Hospitel:	nt 2 ER/C	outpatient	3 🗆 🖸	OA OI	her	ursing H			8 🗆 Oti	ner (Specif	v)
27. Menner of Deeth	28a. Dete of Inju (Month, Da		Time of		28c. Inju	2.5		28d. Describe		_		
1 Neturel 5 Pending investigation		y roary	Injury	М		Yes 2	No					
3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Inj	ury - At home, i	arm, stre	et, fecto	ry, office				(Street en		ber or Rura	I Route Number,
	building, et	. (Opecity)						0.,70,70	, 51616	,		
	ysician: To the best of											
one)	end manner ste											
29b. Signeture end title of certifier				1 194		se number						Day, Year)

D43496

February 16, 1998

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlet-trensit

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

Department of Health and Mental Hygiene. Important: or items 23s or 28s-f show important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumetic avent, it a Macterial Example must be notified as

Physician /Medical Examiner

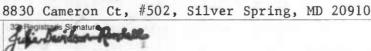
Baltimore, Maryland 21215-0020

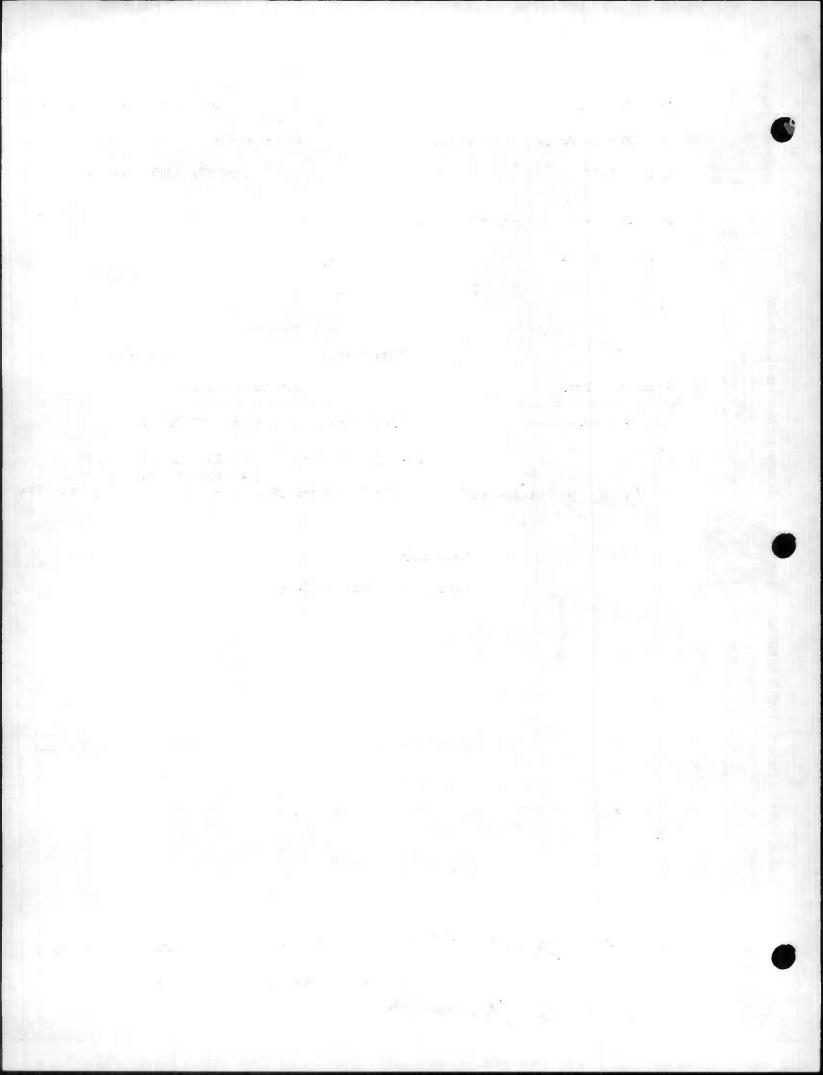
Blog

To Be Completed by Funeral Director

Mohammad Khalid 31. Dete filed (Month, Day, Year)
FEB 171993

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1			Decedent's Neme (First, Middle, La		-	Cer	rtificat	e of	Death	2. Dete of De	Reg. No.	98	0.6901 3. Time of Deeth
/Me	siciar edica mine	1	James Russell Thon 4e. Fecility Neme (If not Institution, giv						4b. City, Town, or	FEBRU. Location of Deal	- T	Year 1998 y of Deeth	2145 PM
LAG			Sacred Heart Hospite						Cumberlan		All	legany	
Fune: Direct				Sex 7. Ag	77	lest birthdey) Yrs.	if Under Months	Deys		8. Date of Bi (Month, Di 15-Jan	-21	9. Birth	piece (State or Foreign nry) Idnd
Merylend H show	1		Usuel Residence of Decedent 10a. Stete 10b. County Maryland Allege	any		y, Town or Lo	cation						10d. Inside City Limits 1 Yes 2 No
th with the 23s or 28s	oi Director		10e. Street end Number 5 Cente	nnial Street	1		10f. Zip	Code 2153	32-		10g. Citizen of U.S.A		ntry?
15-0020 72 hours after death with the Menylend restural; or frems 23s or 28s-f show the mast be notified at	by Europe	2	11. Maritel Stetus 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces? 1 1 Yes 2 1 If If Yes, Give Yeer or Dates:			Was Deced f Yes, spec	2.0	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No to Rican, etc.)		ce - Americ eck, White, fy:White	etc.
		ompleted	15. Decedent's Et (Specify only highest gra Elementery/Secondery (0-12)	ducation ade completed) College (1-4or 5	5+)	16e. Deced (Give iiie. L shipping	kind of wo. DO NOT us	rk done se retire	during most of world)	rking	16b. Kind of E		dustry
aryland 212: should be filed within and Mental Hygiene. s marked other then umatic event, the M	To Be C	0	17. Fether's Neme (First, Middle, Last) Robert T. Thomas, Sr.						18. Mother's Ner Nellie		, Meiden Sume	me)	
Nore, Marylis ges 1 end 2 should It of Health end Mer If Item 27 is merke or other treumstic			19e. Informant's Name/Reletionship (Theresa Thomas	Type, Print) Wife		19b. Meilin 5 Centen			and Number or Ru	ural Route Numb	er, City or Town		21532-
F 9945			20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify		C	lece of Disposemetery, crem	netory or o	ther pla		Dete 2-Feb-98	20c. Location Cumberl		
Baltim permit. Pe Depertmen Important: any Injury	OUCS.		21. Signeture of Funerei Service Licer	Huri	1				ess of Fecility Home, 57 F	rost Ave.,	Frostburg	, MD 2	21532
Physicia /Medic Examin	al		23a. P Enter the disease, or compock, or heart feilure. List only Immediate Cause (Final disease or condition resulting in death)	e. ACUTE	PNEU	MONIA		e of dy	ng, such es cardiad	c or respiretory e	rrest,		Approximete intervel Between Onset end Deeth 36 hours
b8/bU , fficate be executed g physician and es the buriel-transit	Examiner		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	METAST	ATIC	CARCII	NOMA	OF	LUNG TO E	BRAIN			8 months
	an/Medical		Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	d	Due to (or	as e consequ	uence of):						
het the ded by the deteched	v Physician/M		Pert II. Other significant conditions o	ontributing to death bu	ut not resu	ulting In the un	nderlying c	ause gi	ven in Pert I.		tobacco uee co Yes 2∑ No		the cause of death?
3 200	Completed by	-									en autopsy ormed?	ev	ere eutopsy findings elleble prior to impletion of cause deeth?
n: The licate h	Con		OF Mean and a state of the stat							10		1[Yes 2 No
his hy	1	2	25. Wes case referred to medical exeminer? 1 Yes 2 No	Hospital:		ER/Outpetient		A		lome 5 ☐ Resi	dence 6 □Oti		y)
DIVISION OF all or Attanding Physical distributions of the this in the ctor. After this din by the funeral d	Certification:		27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			28b. Time of Injury	м 2	8c. Inju Wo 1 ⊑	ryet rk? ∣Yes 2 □ No		how Injury occu		
DIVI pital or Ati urs efter d rei Direct	- 0		4 Homicide determined	building, etc	c. (Specify	")				City or To	wn, Stete)		al Route Number,
DI To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical		29a. Certifier 1	ysician: To the best on niner: On the basis of end menner sta	exeminat	viedge, deeth ion end/or Inv	occurred (estigation,	ot the ti	me, dete end plece opinion, deeth occu	, end due to the rred et the time,	cause(s) and m dete end piece,	enner es s end due te	teted. o the cause(s)
	Σ	1	29b. Signature end title discertifier				290	. Licen:	se number		29d. Date signe		
3		3	30. Neme end eddress of person who	completed cause of de	eeth (Item	23e) (Type, F	Print)	D08	3377		FEBRUA	ARY 1:	2 1998
mas		3	URIEL VELANDIA 31. Dete filed (Month, Day, Year)	M.D. 902 S		DRIVE	CUM	BER	LAND MD	21502			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death Month **Physician** Vera Cox VanSchaik Feb 9 12:45 AM 1998 /Medical 4e. Fecility Nama (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Easton Talbot Genesis ElderCare -The Pines 5. Sociel Security Number If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 7. Aga (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 1□M 2₩F Deys 75 Yrs. 218-14-4337 Director NOV.19,1922 MARYLAND Usuel Residence of Dacedant with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f show Director 1 Yes 2 No TALBOT EASTON 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7491 OCEAN GATEWAY 21601 death Funeral USA 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, etc. d 2 should be filed within 72 hours after of the and Mental Hygiena.
7 is marked other than "natural", or fler traumatic event, the Medical Examinations 1 Never Merriad 3 Married 1 Yes 2 No If Yas, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Educetion (Specify only highast grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 11 -0-HOUSEWIFE OWN HOME permit. Peges 1 end 2 should be file Department of Health end Mental Hy Important: If flam 27 is marked other any Injury or other traumatic event police. 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Be J. HARPER COX CARRIE SAULSBURY 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) EDWIN G. VAN SCHAIK /HUSBAND 7491 OCEAN GATEWAY, EASTON, MD 21601 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Steta 1 XBurial 2 Cremetion 3 Removal from State SPRING HILL CEMETERY 2 - 13EASTON, MD 4 Donetion 5 Other (Specify) 21 Signeture of Funaral Service Licenses 22. Nema and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immedieta Ceuse (Finel 2 why disease or condition resulting in death) Examiner Examiner 10425 The law requires that the death certificeta be axecuted buriel-trensit Sequentielly list conditions, if any, leeding to immediate ceuse. Entar Underlying Ceusa (Disaase or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physician s the buriel Box 68760. BRUNCONITIS CIGROWIC n Physician/Medicai Due to (or es e consequence of) as esn n P.O. Pert II. Other significent conditione contributing to death but not resulting in the underlying causa given in Pert I. been signed by the should be datached 23b. Did tobacco use contribute to the cause of death? 2□ No 3 □ Probably 4 □ Unknown 2 Records, þ 24b. Were autopsy findings eveileble prior to completion of causa of daath? Completed 24e. Wes en eutopsy performed? page 2 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director. Be 25. Was case referred to medical examinar? 26. Piece of Deeth (Check only ona) Other: 1 Yes 2 No Certification: To 4 Nursing Home 5 ☐ Residence 8 ☐ Othar (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After Neturel 2 Accidant 5 Pending investigation 1 ☐ Yes 2 ☐ No death. eftar death Director: To the Hospital or Atter within 24 hours efter des To the Funeral Director completely filled in by th 6 Could not be determined 28a. Place of Injury - At home, farm, streat, fectory, office building, etc. (Specify) 3 ☐ Suicida Location (Straat and Number or Rural Route Number, City or Town, Stete) 4 - Homicide 1 Cartifying Phyelcian: To the best of my knowledge, daeth occurred et the tima, data end place, end dua to tha causa(s) and mannar as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifian 29d. Date signed (Month, Dey, Year) 29c. License number 1221

State Registrar

TEPHEN

31. Date filed (Month, Day, Year)

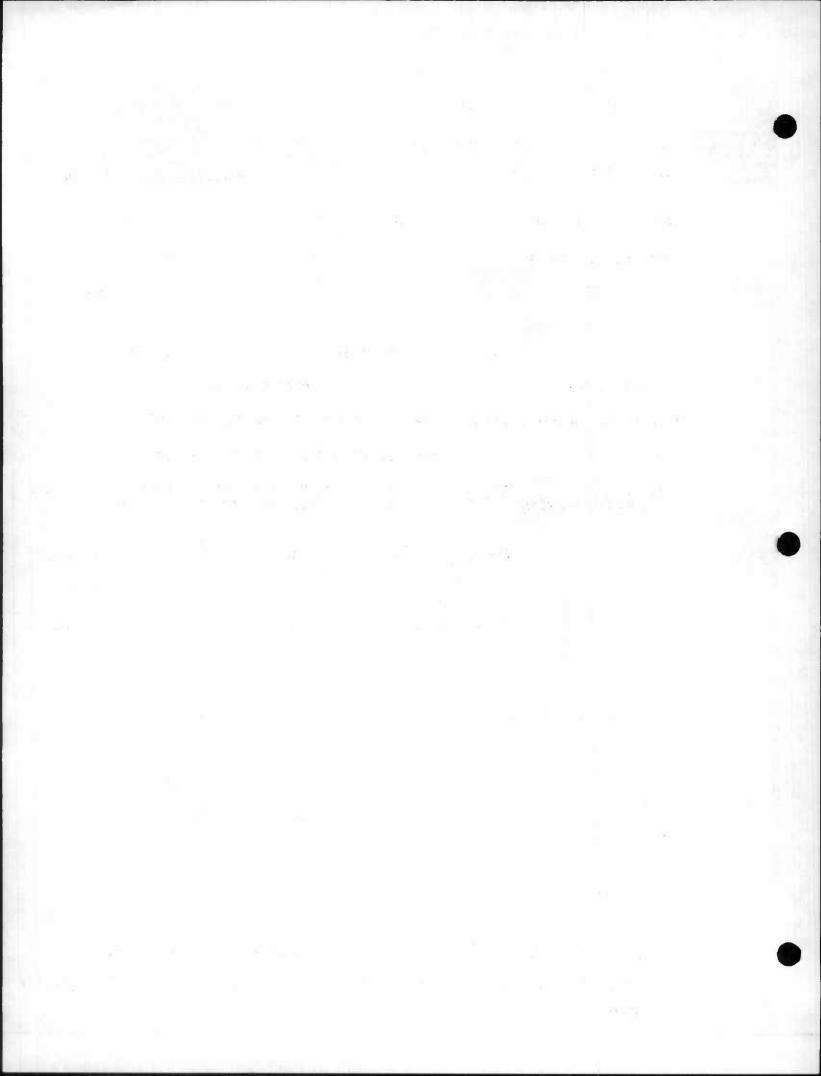
FEB 1 1 1998

30. Name and eddress of person who completed cease of deeth (Item 23e) (Type, Print)

MD

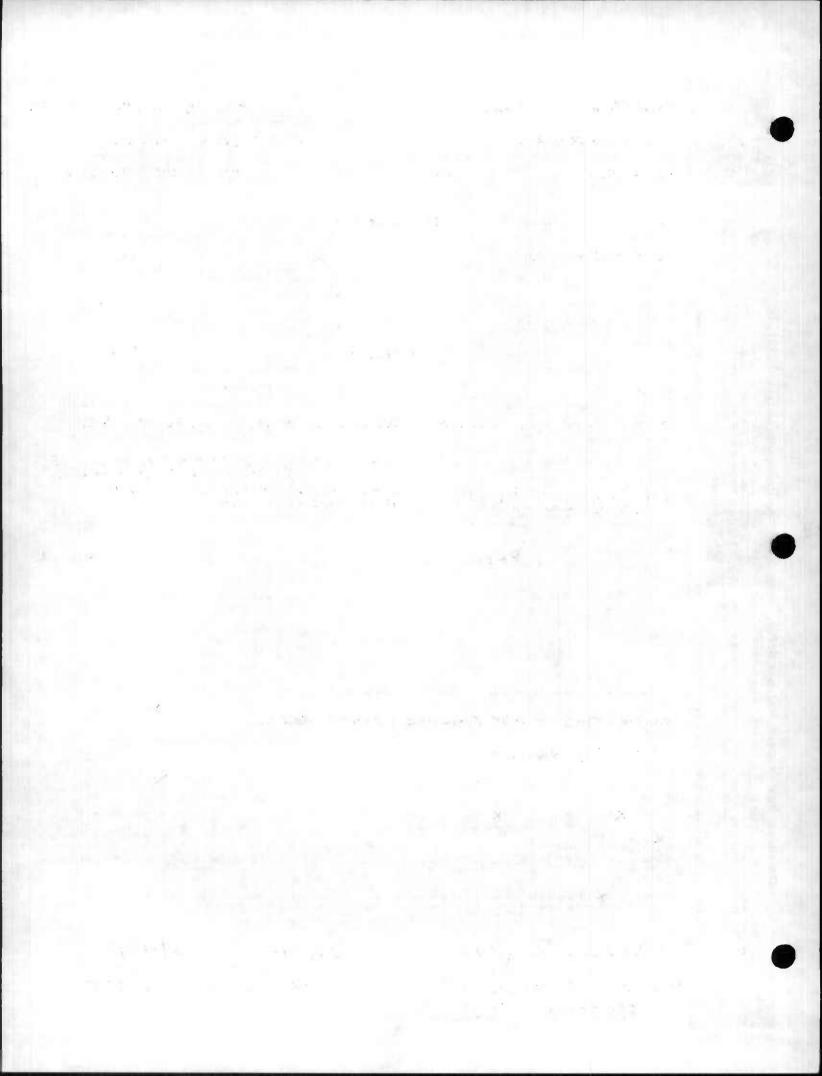
32. Registrar's Signature

Sina Davidson



				n waiyiai	Cer	tificate o				Reg. No. 98	0	6903	
Physician	1. Decedent's Nan								2. Dete of De Month	Day	Yeer	3. Time of De	
/Medical	MARGARE 4e Fecility Neme	T BERNAD					4b. City, To	own, or L	Februa	3		2:27 H	PM
Examiner		oss Hosp					Sil	lver	Spring			7	
Funeral	5. Sociel Security I		Sex	7. Age (In yrs	: last birthdey)	If Under 1 Ye	er If Under	24 Hrs.	9 Date of Bi	dh		lece (Stete or Fi	oreign
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with the Meryland a or 28a-f show be notified at	10e. State	10b. County	2	10c. C	ity, Town or Loc	cation					1	0d. Inside City L	
the Meryle 28a-f ehor notified at	MD	Montg	omery		Silver	Spring						1 ☐ Yes 21	₩ No
vith the Mei t or 28a-f e be notified	10e. Street and Nu	ımber				10f. Zip Code	1			10g. Citizen of V	Whet Coun	try?	
th w	14400 H	lomecrest	Road			20	906				USA		
5-UUZU 72 hours after death v natural; or items 23s stal Exercises usual	3 Widowed	ried 2 Married	Armed F	2 🔯 No ive		Ves Decedent of Yes, specify C			pecify Yas or No Pican, atc.)	o- 14. Rac Blee Specify	e - Americ ck, White, Wh		
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E Sales W			,,					Мос		, , , , , , , , , , , , , , , , , , , ,	.0)		
Maryla d 2 should th and Men 7 ie marke traumatic	19e. Informent's N	lame/Retationship	(Type, Print)		19b. Mailin	g Address (Stre	et end Numb	er or Ru	rei Route Numi	ber, City or Town,	Stete, Zip	Code)	
	Susan E	. Schell	berg (daughte	r) 1170	9 Farml	and Dr	rive,	Rockv	ille, MD	208	352	
0 = 0 = 0		□ Cremetion 3		State	Place of Dispos cemetery, crem				Dete	20c. Location			
tin the tant: tant:		5 ☐ Other (Spec		Gat	te of He	eaven C	emeter	У	2/17/98	Silver J. Colli	Spri	ng, MD	
Balting permit. Pa Department Important: any Injury	21. Signature of F	MANA DI.) (alo	Но	me, Inc. 1ver Sp	. 500	Uni		y Bivd.		merar	
STEEL STEEL	23a. Pert1. Enter shock, or he	tha diseese, or col en failura. List onl	mplicetion thet y one cours on	caused the dea	ath. Do not ente	er tha mode of o	lying, such es	s cardiac		errest,	1	Approximete Intervel Betwee Onset and Dea	en
Physician /Medicai Examiner	Immediate Ceuse disease or conditi- resulting in death)	on	· An	EUMON	or es e conseq	uance off:						me weet	
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s that the de igned by the be detached by Physic	CONGR								1	Yes 2000	3 Pro	bably 4□Un	known
ecord sw requir ss been s 2 should	FAILU	STIVE LE; D	BULNT	· (A	J				24a. We	s en autopsy ormed?	av co	ere autopsy find eilable prior to mpletion ol cau deeth?	
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VITAL IN Inclem: The certificate rector, pag	25. Wes case refe	rred to medical					26. Pled	e ol Dea	th (Check only	one)			
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C g get o		th 5 Pending investigeti		of tnjury oth, Dey Year)	28b. Time of Injury		njury et Vork?]No	28d. Describe	how injury occur	red		
Ca the Cat	2 Accident 3 Sulcide 4 Homicide	6 Could not determine	be 28e. Plec	e of Injury - At I ling, etc. (Spec	home, ferm, stre					(Street end Numi	ber or Rure	i Route Numbe	r,
DIVI To the Hospital or At within 24 hours effer or To the Funeral Direct completely filled in by Medical Certifi			miner: On the b							e ceuse(s) end m , date end plece,			
Me Me		d title of cartiliar	5.70 17/01			29c. Lica	ansa number			29d. Date signe	d (Month,	Day, Year)	
12	1 ha	tuc	Thange	49		D	0894	4		2/14	198		
	30. Neme end edd	ress of person who	o completed cau	se ol deeth (Ite	m 23a) (Type, I	Print)	37	20	FARL	AGUT K	WE		
	MARTIN				atura .		RE	NSIA	JETON	2 14 AGUT X MD 2	089	5	
State	31. Dete filed (Mor	R 1 8 100	0 3	Registrar's Sign	nature								

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month MATSON RITA February 13, 1998 5:50 AM 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year Birthplece (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) Deys Months 1 ☐ M 2 🖾 F Yrs. 578-44-3065 72 Usuei Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8511 Burdette Road 20817 United States 12. Was Decedent Ever In U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bieck, White, etc. 11. Maritei Status 1 Never Married 2 Merried 1 ☐ Yes 2 ☒ No Specify: 3 ☑ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) American Red Cross Nurse 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Alfred Albert DuRivage Sarah LaChance 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 116 Rawlings Road, Gaithersburg, Maryland 20877 Jean Marie Meinke/Daughter 20b. Place of Disposition (Name of cametery, cremetory or other place) Feb. 18, 1998 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Bethesda, Maryland Montgomery Crematorium, Inc. 21. Signetum of Funeral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy M00198 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Chase, Inc. Approximete Intervel Between Onset end Deeth SEPTIC SHOCK Immediate Cause (Final diseese or condition resulting in death) Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Couse (Diseese or injury that Initialed events resulting in death) Last Due to (or es e consequence of): Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? SEVERE CHRONIC OBSTRUCTIVE LYNG- DISEASE 3 Probably 4 Unknown 1 Yes 2 No THE POTHYROLD IS 24e. Wes en eutopsy performed? CHRONIC RENAL INSUFFICIENCY, 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 Yes 2₺ No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Division of Vital Records, P.O. Box 68760 B

Physician

/Medical

Examiner

Physician

/Medical

Examiner

Director

Funeral

p

Completed

Be

Funeral

Director

r than "natural", or items 23a or 28a-f show the Madical Example must be notified at

the Maryland

death

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural" ~ Pages injury or other traumatic averages.

Bur

certificate 名 Affair after death Director:

Examiner Physician/Medicai þ Completed Be Certification: To Medicai

2 Accident 3 Sulcide 4 Homicide

29a. Certifier

(Check only one)

25. Wes case referred to medical 1 Yes 2 No 27. Menner of Deeth 1 Neturel

5 Pending investigation 6 Could not be determined

1 Department 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of

28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 TYes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) end menner stated.

29b. Signetum and title of certifier

29c. License number

28c. Injury et Work?

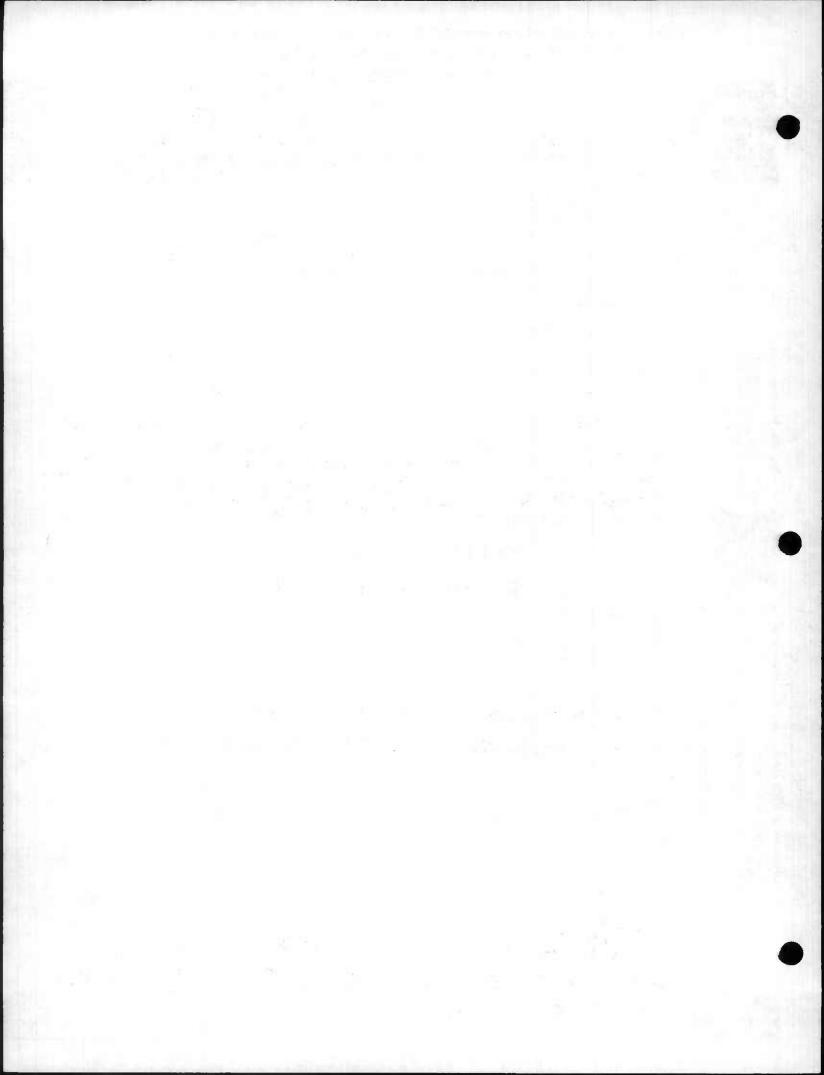
29d. Date signed (Month, Dey, Yeer)

with completed cause of deeth (Item 23e) (Type, Print)

4930 DELRAY AVE BETHESDA, MD 20814 SIMO 22. Registrar's Signeture

State Registrar

To the Hor within 24 h To the Fur

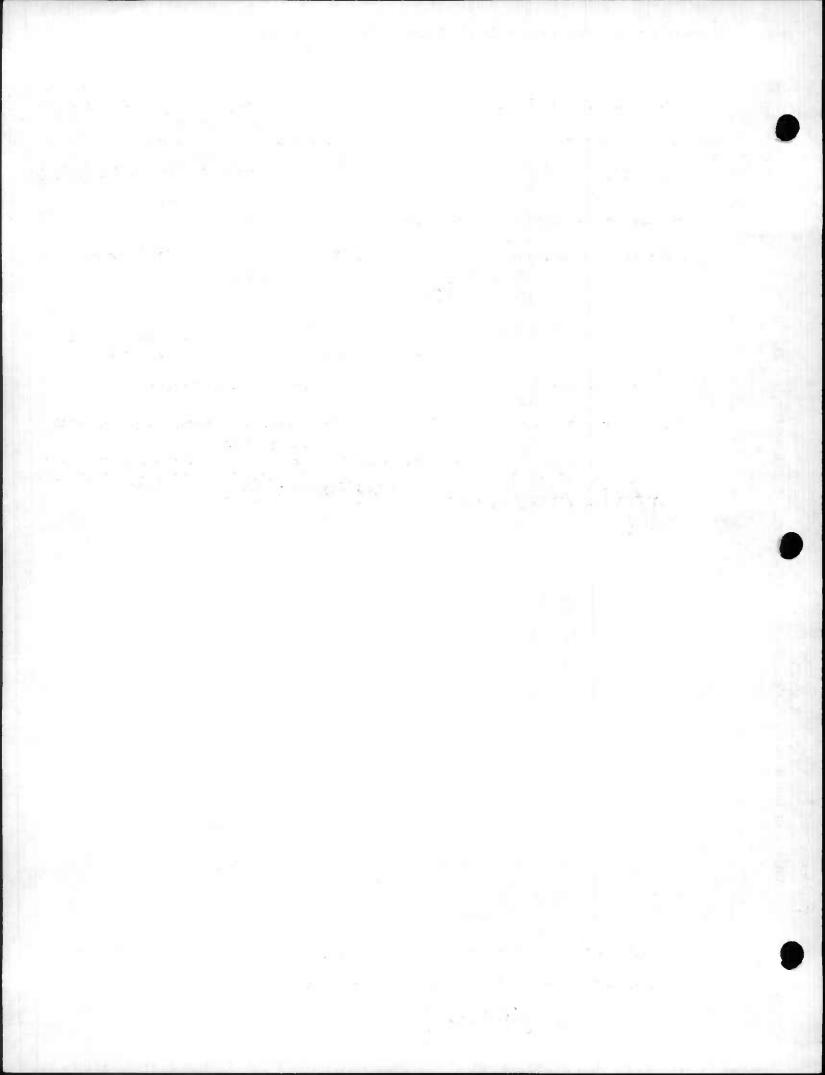


State of Maryland / Department of Health and Mental Hygiene

					- 00	Tunou	te of	Deaiii		Reg. No.		000
Physic	ian	1. Decedent's Neme (First, Middle, Frederick Willi							2. Dete of De Month	Day	Yaar	Time of Deeth
/Med									Februar			1:00 PM
Exami	ner	4a. Facility Neme (If not institution,		7)					Location of Death			
		Suburban Hospit				li li li li li li li li li li li li li l	1	ethesda			gomery	
Funeral Director		5. Social Security Number 578-44-2529 Usual Residence of Decedent	6. Sex 7. A 1⊠ M 2□ F	ga (In yrs. I	Yrs.	Months	er 1 Year Deys	If Undar 24 Hrs Hours Min		th Year) 1935	9. Birthpiece Country) Washing	(State or Foreign ton, D(
ž ==		10e. State 10b. County		10c. City	, Town or L	ocation					10d. li	nside City Limits
6.3	ō	Maryland Montgo	morn	Dor	wood							☐ Yes 21 No
28	Directo	10e. Street end Number	incl y	Der	wood	10f. Z	ip Code			10g. Citizen of	What Country?	
2 2		16809 Camberfor	d Street)855				l States	
2 2	Funeral	11. Meritel Status	12. Was Deceden	t Ever in U.S	S. 13.			ispanic Orlgin? (5	Specify Yas or No		ce - American Ir	
Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by Fur	1 ☐ Navar Married 2 ☑ Marria	Armed Forces	No 195				Spacify:	Specify Yas or No rto Rican, atc.)	Specify Specify	ck, White, etc.	
thurs B.E.	P	15. Decedent's			16e. Dece	dent's Us	uel Occup	ation		16h Kind of B	White usiness/industr	
2 8	Completed	(Specify only highest	grade completed)		(Give	kind of w DO NOT	ork done d	during most of wo	orking	Montgon	160	
e de la	mo	Eiementery/Secondery (0-12)	College (1-4or	5+)	Poli	ce O	fice	r		Govern	-	
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end Mental I Is marked of aumatic eva	To B	William M. Whal	en					Dorothy	V. Water	rholter		
	-	19e. Informant's Neme/Relationshi	p (Type, Print)		19b. Meili	ing Addres	s (Street	end Number or R	urel Route Numbe	er, City or Town,	Stete. Zip Cod	e)
		Irene B. Whalen	/ Wife						et, Derwo			
Department of Health e important: if item 27 is any injury or other traconce.		20e. Method of Disposition		20b. Pl				e)Feb. 1			City or Town,	
onto ht: If		1 Burial 2 □ Cramation 3 4 □ Donation 5 □ Other (Spe						Park	,1990	Do oleved 1	lle Mer	Lanland
ortan Injur		21. Signeture of Funera Service M		rai					hert A	Rockvil	v Funer	ryland
Deperimpoi		1/1/			F	lockv	ille,	Inc.	bert A. 300 West	Montgo	mery Av	enue,
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ate hes been s pege 2 should	Be	25. Wes cese referred to medicel examiner? 1 ☐ Yes 2 ☒ No	Hospitel:	ent 2 🗆 E	R/Outpetie	nt 3 🗆 C	OA Othe	er: 4 Nursing !	Home 5 ☐ Resid	dence 6 Oth	er (Specity)	
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within 24 hours efter death. To the Funeral Director: After this certificate hes been to completely filled in by the funeral director, page 2 should	edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifiar	28e. Dete of Inj (Month, D) 28e. Plece of Iri building, e Physician: To the best taminer: On the basis end menner s	ury by Year) jury - At hor tc. (Specify) of my know of examinetic teted.	28b. Time of Injury ne, ferm, sto	M M reet, fector h occurred vestigetio	28c. Injury World 1 1 1	y et ⟨? Yes 2 □ No ne, dete end pleca pinion, deeth occur e number	28f. Location (3 City or Tow e, end due to the urred et the time,	now injury occur Street end Numb vn, Stete) ceuse(s) and me dete end plece,	ned or Rurel Rou enner es steted end due to the	ceuse(s)
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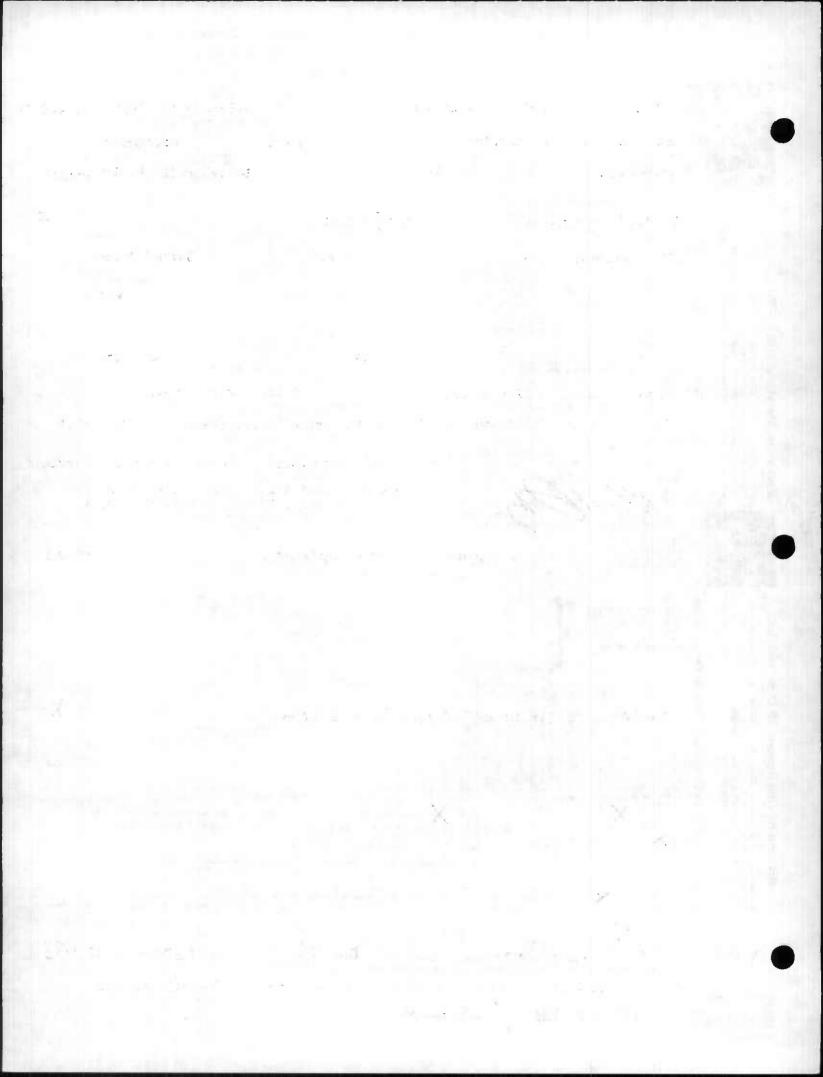
DHMH 16 Rev 6/95

FREdonek



an .	1. Decedent's Nam	e (First, Middle, La	est)				Death	2. Date of De		3. Time of Death
	Winsto	n How	ard W	lilkins	son Jr			Month Februar	Dey 17 19	Year 998 11:00 A
al			ve street and number		3011 31		4b. City, Town, or			
er	The state of the s		al Hospit				Olney		Montgo	omerv
	5. Social Security N	_	-	Age (In yrs. la		Under 1 Year	If Under 24 Hrs		rth	Birthplece (State or Foreig Country)
	577-05-35	36	1 XX M 2□ F	81	Yrs. Mc	onths Days	Hours Min	December	er 31, 1	916 Kentucky
	Usual Residence of	Decedent								
Ì	10e. Stete	10b. County		10c. City,	, Town or Location	on				10d. Inside City Limits
	Maryland	Montgom	nery		Silve	r Spri	ng			1 ☐ Yes XX No
	10e. Street and Nur	mber			1	Of. Zip Code			10g. Citizen of V	What Country?
	15221 Bau	ighman Dr	ive		The Part I	2090	6		United S	States
	11. Marital Status		12. Wes Deceder Armed Forces		S. 13. Was	Decedent of I s, specify Cub	Hispanic Origin? (S an, Mexicen, Puer	Specify Yes or Note (Note 1)	o- 14. Rec Blac	e - American Indian, ck, White, etc.
	1 ☐ Never Marri 3XXWidowed	ied 2 Married 4 Divorced	IV Yes 2 If Yes, Give Year or Dates] No s:	10	Yes 2XXNo	Specify:		Specify	White
	(0)	15. Decedent's E			16a. Decedent	s Usual Occu	pation	dring	16b. Kind of Bu	usiness/Industry
	Elementary/Seco	ndary (0-12)	College (1-40	r.5+)	life. DO I	VOT use retire	during most of wo d)	orking		
l	12	induity (o 12)	2	,		Major			Air	force
-	17. Fether's Name	(First, Middle, Last	t)				18. Mother's Na	me (First, Middle	, Maiden Sumem	
-	Winston	Howard W	ilkinson,	Sr.			Artie	Owens	Smith	
	19a. Informent's No				19b. Mailing A	ddress (Street	and Number or F	lural Route Numi	ber, City or Town,	Stete, Zip Code)
	Winston	Howard	Wilkinson	III	260 Gr	etna G	reen Cou	rt, Alex	andria,	Va. 22304
	20a. Method of Disj			20b. Pla	ace of Dispositio	n (Name of ry or other pla	ce)	Date	20c. Location -	City or Town, State
I		Cremation 3 L 5 ☐ Other (Speci	Removal from States	Θ	t Linco			2-20-98	Brenty	wood, Maryland
l	21. Signature of Fu	neral Service Lice	200		22. Na	me and Addre	ess of Fecility			
l	1/1/		ti.							11800 New
	23a, Part 1, Enter t	ne disease of con	nplicetion that caus one case on each	ed the deeth.	. Do not enter th	e mode of dy	Ave., Sing, such es cardia	c or respirefory	errest, Md.	Approximate
	shock, or hea	rt failure. List only	one dise on each	line.						Interval Between Onset end Deeth
	Immediate Ceuse		C' > 0 .	14050	1000	7-	S CAAC			JEAN
	disease or condition resulting in death)	n	a. CORD				- DENLOG			LENKA
5				D09 t0 (01	es e consequen	ce oi).				
			b							
а	Convention live line and	audition of		Due to (or	neumeanne as	ce of):				
	Sequentially list co if any, leeding to in ceuse. Enter Unde	nditions, nmediate		Due to (or	as a consequen	ce of):				
	Sequentially list co if any, leeding to in ceuse. Enter Unde Cause (Disease or that Initiated events		c							
	Sequentially list co if any, leeding to in ceuse. Enter Unde Cause (Disease or that Initiated events resulting in death)		c		as a consequen					
	that initiated events		c							
	resulting in death)	Lest	cdcontributing to death	Due to (or	as e consequen	ce of):	ven in Part I.	23b. Dic	f tobacco use co	entribute to the cause of death
	resulting in death) Part II. Other signif	lest		Due to (or	as e consequend	ce of): tying ceuse gi			f tobacco use co] Yes 2 □ No	ontribute to the cause of death
	resulting in death)	lest	cdcontributing to death	Due to (or	as e consequend	ce of): tying ceuse gi	ven in Part I.			1/
	resulting in death) Part II. Other signif	lest		Due to (or	as e consequend	ce of): tying ceuse gi		1 = 24a. Wa		3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to
	resulting in death) Part II. Other signif	lest		Due to (or	as e consequend	ce of): tying ceuse gi		1 = 24a. Wa	Yes 2□ No	3 ☐ Probably 4 ☐ Unknown
	resulting in death) Part II. Other signif	lest		Due to (or	as e consequend	ce of): tying ceuse gi		1 24a. Wa	Yes 2□ No	3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause
	Part II. Other significance of the control of the c	Icant conditions		Due to (or	as e consequend	ce of): tying ceuse gi	SEASE	1 24a. Wa	yes 2 No	3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of deeth?
	Part II. Other significance	Icant conditions		Due to (or but not result	as e consequent	tying ceuse gi	26. Place of De	24a. Wa peri	yes 2 No	3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 Yes 2 No
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	Part II. Other significance of the control of the c	Icant conditions Icant condit	Hospitat: 1 Inpa 28a. Date of Ir (Month, L) 28e. Place of building, hysician: To the besi	Due to (or but not resultient 2 Enjury 2ay Year) Injury - At hotelc. (Specify,	as e consequent liting In the under Liting In the under Liting In the under Liting In the under Liting In the under	tying ceuse gi	26. Place of De her: 4 \(\triangle	24a. Wa peri 1 Death (Check only Home 5 Describe 28d. Describe 28f. Location City or Total Research and due to the	Yes 2 No s an autopsy formed? Yes 2 No one) sidence 6 Ott how injury occur (Street and Numbown, Stete)	3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 Yes 2 No ner (Specify) rred ber or Rural Route Number,
	Part II. Other algnift 25. Was case referexaminer? 1 Ves 27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	red to medical No Description of the control of th	Hospitat: 1 Inpa 28a. Date of Ir (Month, I) 28e. Place of building,	Due to (or but not resultient 2 Enjury 2ay Year) Injury - At hotelc. (Specify,	as e consequent liting In the under Liting In the under Liting In the under Liting In the under Liting In the under	be of): tying cause given by the property of	26. Place of De her: 4 \(\triangle	24a. Wa peri 1 Death (Check only Home 5 Describe 28d. Describe 28f. Location City or Total Research and due to the	San autopsy formed? I Yes 2 No none) Sidence 6 Other how injury occur (Street and Number own, Stete) e ceuse(s) and men, date end place, date end place,	3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 Yes 2 No ner (Specify) rred ber or Rural Route Number,
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	25. Was case referexaminer? 1 Yes 27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	red to medical No h 5 Pending investigation of determined 1 Certifying P 2 Medical Exa	Hospitat: 1 Inpa 28a. Date of Ir (Month, I) 28e. Place of building, hysician: To the best miner: On the basis and manner	Due to (or but not resultient 2 F July Day Year) Injury - At hotelec. (Specify, st of my know of examinetistated.	as e consequence liting in the under liting in	be of): tying ceuse gi DOA 28c. Inju Wc M 1 factory, office curred et the t gation, In my	26. Place of De her: 4 Nursing ry at rk? 1 Yes 2 No note the control of the cont	24a. Wa period at the time	yes 2 No s an autopsy formed? Yes 2 No one) sidence 6 Ott how injury occur (Street and Numb own, Stete) e ceuse(s) and me o, date end place, 29d. Date signe	3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 Yes 2 No ner (Specify) rred ber or Rural Route Number, enner es stated. and due to the cause(s)
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 8 06907

				Cei	rtificate	of	Death			Reg. No.			
	1. Decedent's Name (First, Middle	e, Last)							2. Date of De	ath		Vac-	3. Time of Death
Physician	Catherine	Bernadett	e Willem	in					Month Februar	Day		Year 998	7:57 AM
/Medical Examiner	4a Facility Name (If not institution			7.11			4b. City, To		cation of Deat	-	County		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Examine	11028 Burnley	Terrace					Silve	r Sn	rino	1	Mont	gomen	rv
	5. Sociel Security Number		7. Age (In yrs. last	birthday)	If Under 1				8 Dete of Bir	th	T	_	-
Funeral Director	038-20-5247	1□M 20%F	79	Yrs.	Months	Deys	Hours	Min.	June 1:	IV. Year)	018	Coun	lace (State or Foreigntry) de Island
Director	Usuel Residence of Decedent		13						Julie 1.	J, 1.	910	KIIOC	ie istanu
A 11	10a. State 10b. County		10c. City, T	own or Lo	ocation							1	0d. inside City Limit
of a Po	MD M		C	4 3	C								1 ☐ Yes 2 ☑ N
or 28a-f si be notified Director	MD Monts	gomery	5	TIVE	r Spri	-				100 00	inon of 18	/hat Coun	Chart
D 80		-								Tog. Citi			my r
1 23 I	11028 Burnley					209					US		
al, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	11. Marital Status	12. Wes Deca Armed For	dent Ever in U,S.	13.	Was Decede If Yes, specif	ent of F fy Cub	tispenic Orig an, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.))-		k, White,	an Indian, etc.
P. III	1 Never Married 2 Man	If Yes, Giv			1 ☐ Yes 2	⊠ No	Specify:				Specify:	T.TL 4	
natural, or adical Examileted by F	3 Widowed 4 Divorced	Year or Da									оросту.	Whi	.ce
nt, the Medical	15. Deceden	t's Education st grade completed)	1	6a. Dece	dent's Usual kind of work	Occup	ation	of worki	ina	16b. Ki	ind of Bu	siness/inc	dustry
vent, fre Med	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use	retire	d)						
T FO	12			Homei	maker					Own	n Hoi	ne	
9 6	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle	, Maiden	Sumam	9)	
To B	Thomas Fitzgera	ald					Mary	Hel	en McDe	ermo	tt		
traumatic e	19a. Informant's Name/Relations			19b. Mailir	ng Address ((Street	and Numbe	or or Rura	I Route Numb	er, City o	r Town,	State, Zip	Code)
r tra	Louis P. Willer	min (hus	band)	11028	8 Rurn	ilev	Terr	ace.	Silve	r Sp	rino	, MD	20902
redto	20a, Method of Disposition	(mus	20b. Place	a of Dispo	osition (Name	e of			Date				wn, State
ò	1 ☐ Buriai 2 ☐ Cremation		State	etery, crei	matory or oth	her pla							
aulinu)	4 Donetion 5 Other (S		Gate	of l	Heaven	. Ce	emeter	y 2	/16/98	Sil	ver	Sprin	ng, MD
eg .	21. Signature of Euneral Service	Ligensee			2. Na <i>m</i> e and ome . I				ancis . versit				merar
a di	Suffy	//	4		ilver		ing.	MD	20901	y DI	vu.	WESL	
	23a. Bert 1. Enter the disease, of shock, or heart failure. 4 as	complications that co	eused the deeth. [or respiratory a	rrest,			Approximate
cian	shock, or near tenure. 4250	only one cause on ea	ach line.									1	Onset and Death
ical	Immediate Cause (Final		0-1-1	111.		ro.	2		STSTE	2	BUR	100	1 and
er	disease or condition resulting in death)	Θ	CENT			6121	1045	() , - , ,		17-6	/14/2	(DU+
e 1			Due to (or as									i	6 nos
든		b	THROI			WIY	7					i	6 11-00
Examiner	Sequentially list conditions, if any, leading to immediate		Due to (or as									į	
edical Examin	cause. Enter Underlying Cause (Disease or Injury	C	n tu	0015	PLAS	A							
edicai	that Initiated events resulting in death) Last		Due to (or es	e conseq	quence of):								
A		d											
ician/Med													
Physician/A	Part il. Other aignificant condition	ons contributing to de	ath but not resultin	g in the u	inderlying ca	use gi	en in Part I		23b. Did	tobacco	uee con	tribute to	the cause of deat
Physician									10	Yes 2	□ No	3 Prol	bably 4 Unkno
by P													
Completed by									24a. Was	an auto	psy		ere autopsy findings elleble prior to
e									pen			CO	mpletion of cause death?
Comp									45	Vac ~	T No		
ပိ								=			No No	11	☐Yes 2☐No
To Be	25. Was case referred to medica examiner?	Hospital:				OH	nor:		Check only				
2	1 Yes 2 No	1 1 1		/Outpatier		A	4 LI NU		me 5 Pres		-	er (Specif	y)
on:	27. Manner of Death 1 DNatural 5 Pendir	28a. Date of	of Injury h, Day Year) 28	lb. Time o Injury		Sc. Inju			28d. Describe	now inju	ry occurr	ed	
ati	2 Accident Investi	gation			М	1 🗆	Yes 2□						
THE T	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined Zee. Place	of Injury - At home	, farm, str	reet, factory,	office			28f. Location (City or To			er or Rure	el Route Number,
Certification:		23,101	g. 2.2. (Speciff		,								
, ie	29a. Certifier 12 Certifyir	g Physician: To the	best of my knowled	dge, deat	h occurred a	t the ti	me, date an	d piaca,	and due to the	ceuse(s) and ma	nner as s	tated.
edicai	(Check only 2 Medical one)	Examiner: On the ba and mann		and/or in	ivestigation,	in my o	opinion, dea	in occurr	ed at the time,	date and	u piaca, a	and due to	une cause(s)
completely filled in by the funeral Medical Certification:	29b. Signeture end title of certifie	r	1		29c.	Licens	se nu <i>m</i> ber			29d. Da	te signed	(Month,	Dey, Year)
-	& due a	i Sc	hongo			170	60			6	2/13	174	
	7 704 5	, -	, , , , , , , , , , , , , , , , , , ,	- \ CT		173	80					•	
	30. Name and address of person								0.11-			ME	20000
	Stanley Sch				cal P	ark	Dri	ve,	Silver	Spri	ing,	rii)	20902
State	31. Date filed (Month, Day, Year)	1000 32.R	egistrar's Signature	m.	.00								
gistrar	LEDI	330 74	AND THE PROPERTY OF THE PARTY O	-Nove									

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month **JAMES** WOODS 15, 11:40 AM ROY FEB 1998 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ARTIC 4804 ROCKVILLE MONTGOMERY If Undar 1 Yaar If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)
AUG. 12, 1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days **M** M 2□ F 71 Yrs. Director 727-01-7743 PA. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits "natural", or items 23s or 28s-f show solical Examiner must be notified at Director 1 Yes 2 □ No MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with CT. 4804 ARCTIC 20853 U.S.A. Funeral 12. Was Decedant Evar in U,S.
Armed Forces?
1∆ Yes 2□N0 944—
I Yes, Giva
Year or Dates: 194 Was Decedant of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
nnt: If Item 27 is marked other than "natural", or itel into or other traumalic avent, its Market in the families in yor or other traumalic avent, its Market in the families. 1 ☐ Never Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify 3 Widowad 4 Divorced 1947 WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Elementery/Secondery (0-12) College (1-4or 5+) LAB. TECHNICIAN 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 86 ANTONIO DIAS ANNA KRAMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 s Department of Heelth er Important: If Item 27 Is any Injury or other trau MARIE A. WOODS/WIFE #10 SAME AS ITEM 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/18/98 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensea 22. Name and Addrass of Facility SILVER SPRING, MD. M00091 CHAMBERS FUNERAL HOMES, P.A. 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** /Medicai immediate Cause (Final disease or condition resulting In death) Examiner The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest end Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of) for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ page 2 should Be Completed 24a. Was an autopsy performad? 24b. Were autopsy findings available prior to completion of cause of deeth? this certificate hes 2 1 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Daath (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending Investigation 1 Natural 1 Yes 2 No s efter death 2 Accident filled in by the 3 Suicida 6 Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatura and titia of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) onnectical Ave, 10810 C OV 31. Date filed (Month, State Registrar

DHMH 16 Rev 6/95

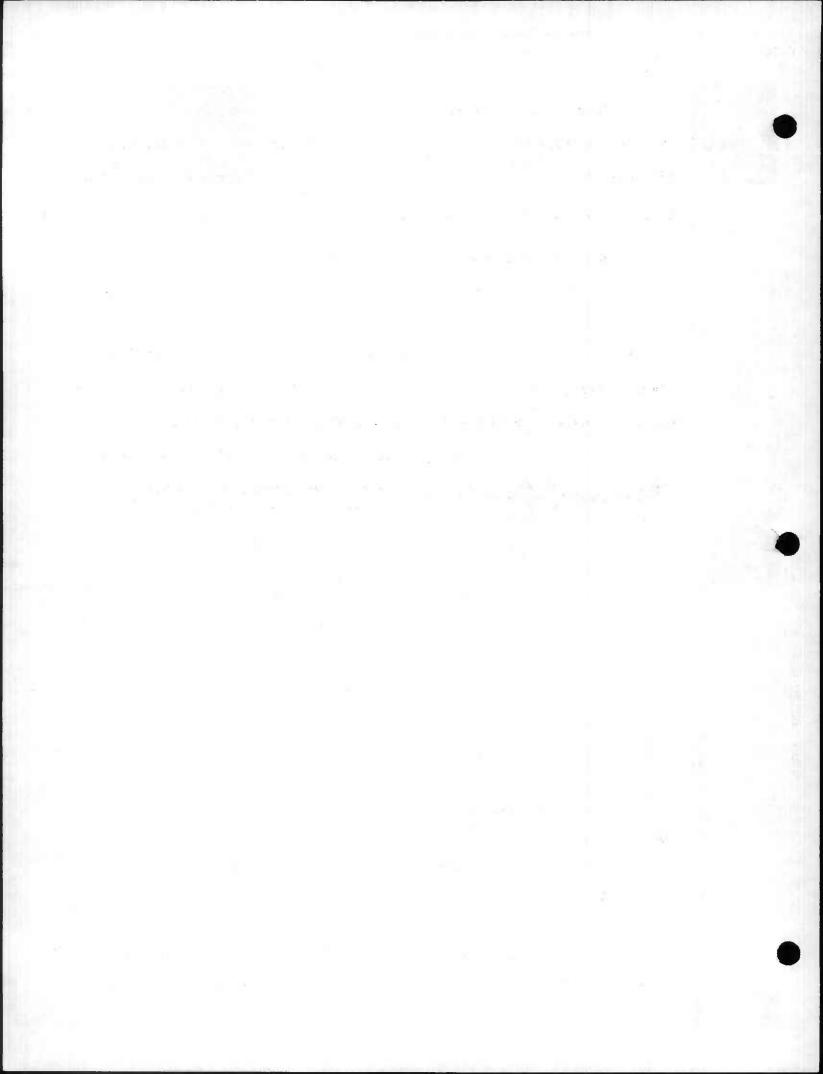
Brus

State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Mary Louise Wheeler February 14 1998 10:54 PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Birthplace (State or Foreign Country) Deys 1 □ M 2 🖾 F Months Hours Min. 66 Yrs. Director 579-48-2719 February 3,1932 Maryland Usual Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director Maryland St. Mary's Chaptico 1 ☐ Yes 2 NO No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Pages 1 end 2 should be filed within 72 hours after death with real of Health end Mental Hyglena.
Int: If I flem 27 is marked other than "natural", or items 23a or intry or other traumatic event, the Medical Examiner mat 23844 Chaptico Wharf lane 20621 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, Whita, etc. 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 ☐ Yes 2 X No Specify: White Completed by Specify 3 X Widowed 4 □ Divorced 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elemantary/Secondery (0-12) College (1-4or 5+) 9th Homemaker Own Home Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Surneme) Be James Harry Knott Elizabeth Alice Thompson 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Charles Albert Wheeler/Husband P.O.Box 302, Chaptico, MD 20621 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Buriel 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Injury Sacred Heart Cemetery 2/18/98 Bushwood, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licanses 22. Name end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, MD 20650

23a. Pertl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock or haart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediata Causa (Final Congestive Heat Failure
Dua to (or es e consequence of): disease or condition resulting in death) **Examiner** Examiner The law requires that the death certificete be executed the burial-transit Sequantially list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest 1a betes Mell, ous Physician/Medical been signed by the attending p should be detached for use as P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Records, Completed by 24b. Ware autopsy findings eveilebla prior to completion of cause of daath? 24e. Wes en eutopsy performed? paga 2 hes certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director. 25. Was case raferred to medical axaminer? Be 26. Pleca of Daath (Check only ona) Hospitel: 1 Thipatient Othar: 4☐ Nursing Home 5☐ Residenca 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpetient 3 DOA this funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 1 Naturel 2 Accident 5 Panding death. investigation 1 ☐ Yes 2 ☐ No 24 hours efter deal Funeral Director: 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide Hospital 1 Cartifying Phyelclen: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es stetad.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner stated. Medical 29a. Certifier completaly (Check only one) within 2 To the ! \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D50672 February 17, 1998 30. Nema and addrass of person who complated cause of death (Itam 23a) (Type, Print) MARGARET A.DALY M.D. 662 MOAKLEY ST. SUITE 101 LEONARDTOWN, MD. 20650 31. Data filed (Month, Dey, Yaar) 32. Registrer's Signeture State ale Barden Rardall FEB 17 Registrar

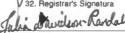
MARY LOUISE WHEELER

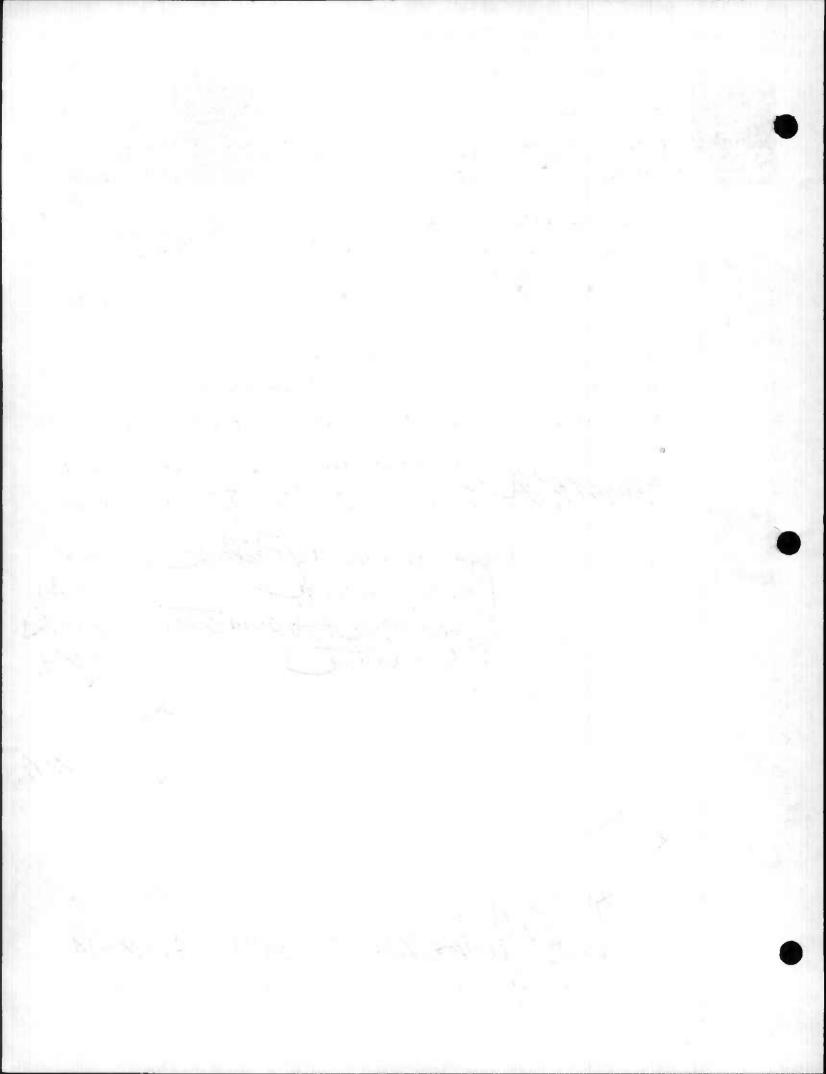


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedant's Nam	ie (First, Middle, Li	ast)					2. Date o		24200	3. Time of Death
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/Medi Exami		4a. Facility Name (I			ber)			4b. City, Tow	n, or Location of D		ounty of Death	0.00 111
Exami		St Mar	y's Hosp	ital				Leor	ardtown	Ct	. Mary	10
Funeral		5. Social Security N			7. Age (In yrs.	last birthday)	if Under 1 Yaar	r If Under 2		Birth Day, Year)		place (State or Foreigntry)
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Mary F sh	to	Maryland	St. M	ary's	F	Ridge						1 ☐ Yas 2 ■ N
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or oth		20a. Method of Disp	cosition Cremation 3	Bamoual from S		Place of Dispo cemetery, crer	osition (Name of matory or other pla	ace)	Date	20c. Loca	tion - City or To	own, State
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Deperminant in any ir		Valle	40/11 5	my Je			Brinsfie	eld Fur	eral Hom	e, P.A.		
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'e Nama (First, Middla, Last) 2. Deta of Deeth 3. Time of Death **Physician** 15, 1998 February 1400 Mervin Sidney White, Sr. /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 46563 Midway Drive Lexington Park St. Mary's If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 1 M 2□ F Months Devs Hours August 17, 1944 53 217-46-5019 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ■ No Directo Maryland Lexington Park St. Mary's 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? United States 46563 Midway Drive 20653 Funeral 14. Race - American Indian, Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Maritel Status 12. Wes Decedent Ever in U.S. Bleck, White, etc. 1 ☐ Yes 2 ■ No 1 Never Married 2 Married If Yes, Give Yeer or Dates: 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Brick Layer Masonry 18. Mother's Neme (First, Middle, Malden Surnama) 17. Fether's Neme (First, Middle, Last) Virginia White Charles Shorter 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Wife 46563 Midway Drive, Lexington Park, MD 20653 Mary C. White 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ■ Buriei 2 □ Cremetion 3 □ Ramovel from State 4 ☐ Donetion 5 ☐ Other (Specify) Luke's Cemetery 2/19/98 | Scotland, Maryland 22. Name end Address of Fecility theral Se Brinsfield Funeral Home, Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leo 23e. Pertl. Enter the diseasa, or complications that causad the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 Approximete Intervel Between Onset and Deeth Immediete Ceuse (Final disaasa or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy completion of cause of deeth? 2 No 1 Yes 1 Tyes 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28c. Injury et Work? 28b. Time of 1 Naturei 5 Pending 1 Yes 2 No investigetion 2 Accident

certificate be executed physician and the bunal-trans as 950 jo signed by the a P.O. Records, peed Dage 2 certificate Division of Vital Attanding Physician: funeral director, this After eftar daeth. Director: Aft ò 24 hours Hospital

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

the Marylend

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death

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al Hygiana.

permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Itam 27 Is marked oth-any injury or other traumatic svem

Physician /Medical

Examiner

traumatic svent.

Maryland 21215-0020

Baltimore.

Examiner Physician/Medical by Completed Be 10 Certification:

> Medical James P.

28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es stated.
2 Medicat Examiner: On he bash of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pieca, and due to the ceuse(s)

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29b. Signature and title of §

6 Could not be

29d. Data signed (Month, Dey, Year)

30. Name and address q deeth (Item 23e) (Type, Print)

Leonardtown, Maryland 20650

31. Dete filed (Month, Day Year) State 18 Registrar

3 Suicida

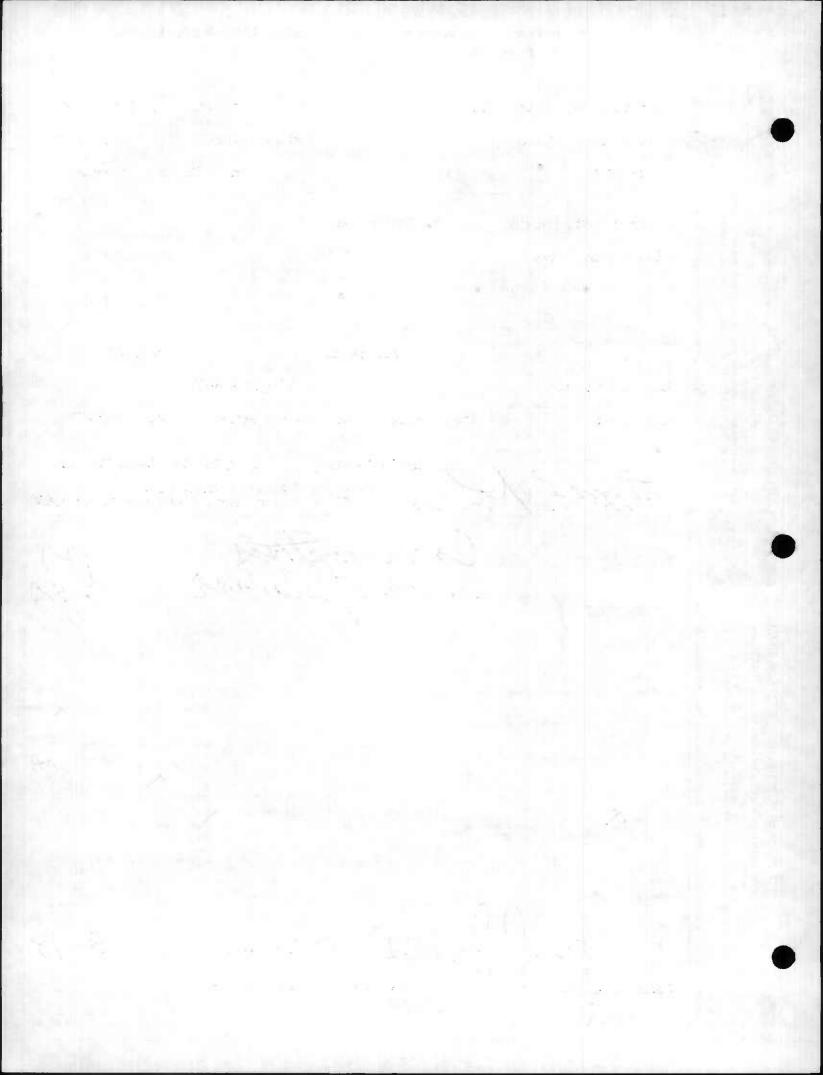
29a. Certifier

4 ☐ Homicide

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Jarboe, M.D. Alawelen hardall 1998

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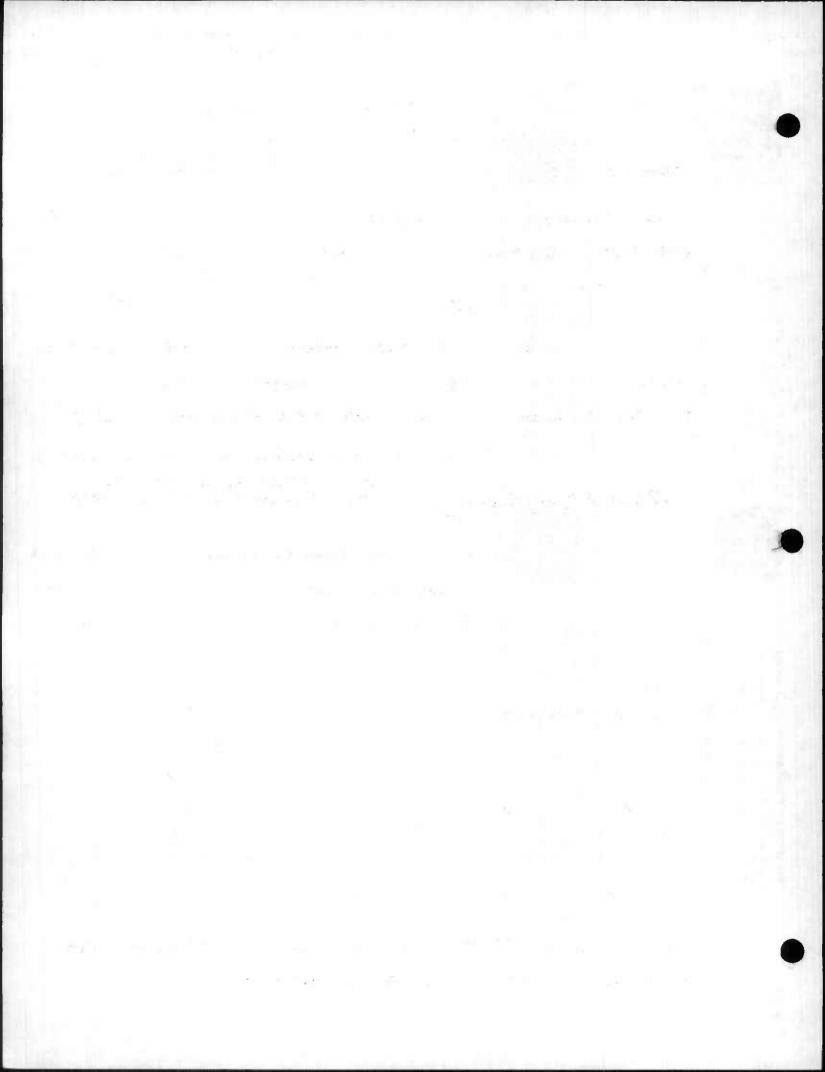


State of Maryland / Department of Health and Mental Hygiene 8 069 2

				Certi	ificate of	Death		Reg. No.	
Physician		1. Decedant's Nama (First, Middla, Last)				2. Data of Dea	ath Day	3. Tima of
/Medical	1	JANES		WH			Februar	4 18,19	
Examiner		The Johns H	opkins 14				more	4c. County	of Death
Funeral Director		5. Social Sacurity Number 449-76-1129 Usual Rasidance of Decedant	7. Aga (In) 9 M 2□ F 51		If Undar 1 Yaar Months Days	if Undar 24 Hrs. Hours Min.	8. Data of Birt (Month, Day Jul 25,	h y, Year) 1946	9. Birthplaca (State o Country) Texas
How H	1	I Oa. State 10b. County	10c	. City, Town or Loca	ation				10d. Inside Cl
r 28a-1 show	į]	Maryland St. Mary	7's	Hollywo	ood				1 🗆 Yas
r items 23s or 28s-f show rings must be notified at Funeral Director	1	loe. Street and Number 44680 Clarks Landi	ing Road		10f. Zip Coda 2063	6		10g. Citizen of W	·
al', or its Examine by Fu	2	11. Marital Stetus 1 Nevar Married 28 Married 3 Widowed 4 Divorced	12. Wes Decedant Evar in Armed Forcas? 1 ☑ Yas 2 ☐ No If Yes, Giva Yaer or Datas:196	15	es Decedant of F Yas, specify Cub	dispanto Origin? (S en, Mexican, Puart Specify:	pecify Yas or No- o Rican, atc.)	14. Race Blac Specify	e - Amarican Indian, k, Whita, atc. White
ygiene. ner than "natural", rt, the Medical Ext		15. Decedant's Edu (Specify only highest grad	cation	16a, Dacedar	nt's Usual Occup	pation	kina	16b. Kind of Bu	sinass/Industry
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azith and n 27 le m		19a. informant's Name/Ralationship (Ty Karen Lee White/Sp				and Number or Ru Landing 1			Steta, Zip Coda) MD 20636
Department of Health and Mental Hygiens. Important: If item 27 is marked other than "naturally any injury or other traumatic event, tra Medical social. To Be Completed	2	20a. Mathod of Disposition 1 ☐NBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donetion 5 ☐ Othar (Spacify)	tamovai from Stata	b. Placa of Disposit cematery, crama Vergreen			Data 5 2/21/9		City or Town, Steta
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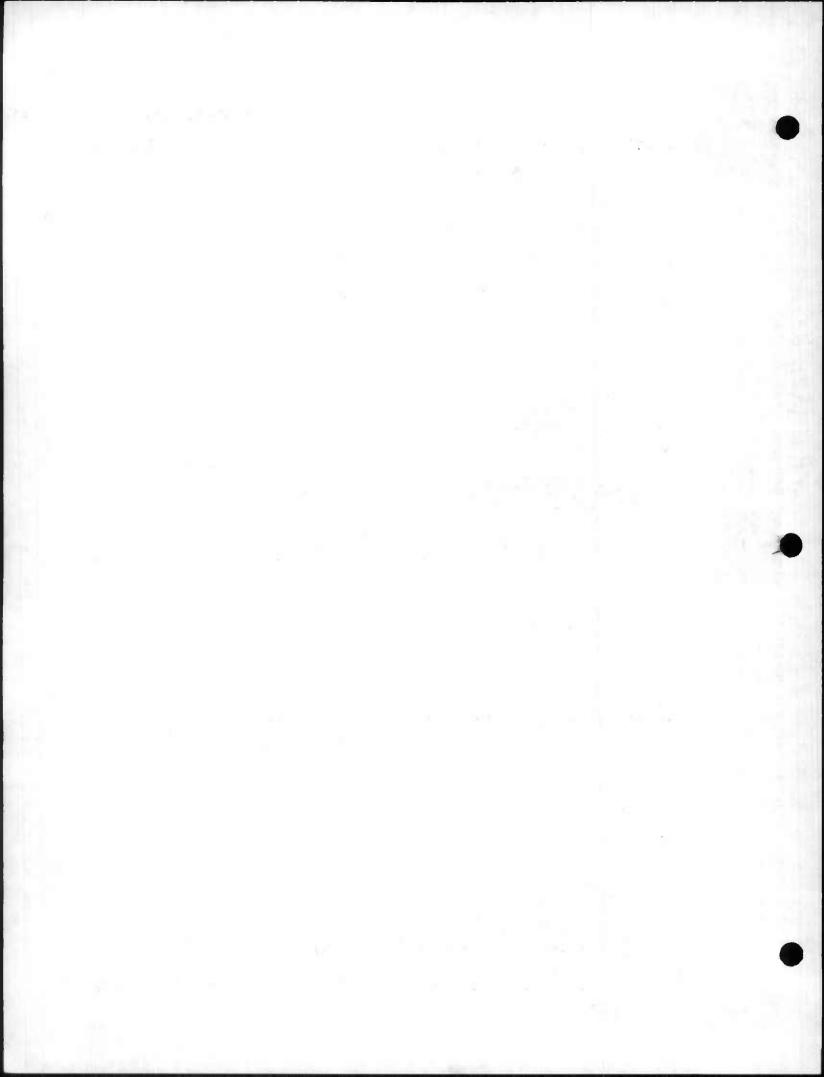
DHMH 16 Rav 6/95

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State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.
hysician /Medical	1. Decedent's Name (First, Middle, Last) Hilda Louvenia Wilson	2. Date of Do Month Februa	ary 12, 1998 10:15 A
ineral rector	4a. Facility Neme (If not institution, give street and number) Memorial Hospital at Easton 5. Sociel Security Number 214348430 6. Sex 1□ M 2■ F 64		Talbot
	Usual Residence of Decedent	wn or Location	10d. Inside City Limits
28a-1 sh	Maryland Talbot Trapp	pe 101. Zip Code	1 ☐ Yes 2 No
r items 23a or 28a-1 s wher must be notified Funeral Director	4117 Ocean Gateway	21673	USA
Examiner of the Pune	11. Marital Stetus 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	13. Was Decadent of Hispanic Origin? (Specify Yes or Niff Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:	o- 14. Race - Americen Indien, Black, White, etc. Specify: Black
rt, ine Medical I	(Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry Private Family
To Be Co	10th 17. Fether's Neme (First, Middle, Last)	Domestic 18. Mother's Neme (First, Middle Lottie Emory	
traumati		b. Malling Address (Street and Number or Rural Route Numb	
Important: If item 27 is marked other than "natural" or items 23s or 28s-f show any injury or other traumatic event, the Madical Exeminer must be notified at once. To Be Completed by Funeral Director	20e. Method of Disposition 20b. Place of cemeter 1 M Burial 2 Cremation 3 Removal from State	pt. 716 Race Street, Cambrid of Disposition (Name of ery, crematory or other place) rsville Cemetery 2/17/98	20c. Location - City or Town, Stete Easton, Maryland
importa any inju once.	21. Signature of Funeral Service Disenses	22. Name end Address of Facility Bennie Smith Funeral Ho P.O.Box 1687, Easton, Ma	ome
edical aminer	23a. Part1. Enter the disease, or complications that caused the death. Do shook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or es a	e not enter the mode of dying, such as cardiac or respiratory and the consequence of):	Approximate Interval Between Onset end Death
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rector, pege 2 s	25. Wes case referred to medical		Yes 2 No 1 Yes 2 No
a p	examiner? 1 Yes 2 No 27. Manne of Death 1 Naturai 5 Pending investigation 1 Accident Hospitel: 1 Inpatient 2 ER/O 28a. Date of Injury (Month, Day Year) 28b.		
filled in by the funeral	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, f. building, etc. (Specify)	arm, street, factory, office 28f. Location City or To	(Street and Number or Rural Route Number, own, Stete)
mpletely fill	(Check only one) 2 Medical Examiner: On the basis of examination at end manner stated.	nd/or investigation, in my opinion, death occurred at the time,	, date end place, end due to the cause(s)
03	29b. Signature and title of certifier James Sales	29c. License number D31376	29d. Date signed (Month, Day, Year) 2-73-98
	30. Name and address of person who completed cause of deeth (Item 23e) James Siles 920 Ma	(Type, Print) NKet St Deuton	MQ 21629
State	31. Date filed (Month, Day, Year) 32. Registra's Signature	Irms Bronda 00	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth Month Day February 20 1998 To af Death 4c. County of Deeth 1 Decedent's Nama (First Middle Last) Kober 6:05 94 4a. Fecility Nama (If not institution, give street and number) City, Town, or Location of Death Hopkins Hospitel altimore Baltimore City Hours Min. 8. Data of Birth (Month, Day, Year) Oct. 24, 1930 5. Social Security Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign 10 M 2 ☐ F Days Ohio 293-24-6965 67 Usual Rasidance of Decedant 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Somerset 1 Yas 2 XNo Marion Station 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5984 Charles Cannon Road 21838 USA 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yes 2 M No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Real Estate Realtor 12 17. Fether's Nema (First, Middle, Last) 18. Mothar's Name (First, Middle, Malden Sumame) Don V. Wilson Annette Mitchell 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5984 Charles Cannon Road - Marion Station, MD 21838 Martha B. Wilson (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata Salisbury Crematory 2/23/98 Salisbury, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility Bradshaw & Sons Funeral Home 21. Signatura of Funaral Servica Licensaa Robert H. Bradshaw 306 W. Main St. - Crisfield, MD 21817 23a. Part1. Enter the diseasa, or complications that causad tha daath. Do not antar tha moda of dying, such es cardiec or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina. Approximete Intarval Batween Immadlate Causa (Final disaasa or condition resulting in death) Due to (or as a consequence of): Sequantially list conditions, if any, laading to immediata causa. Enter Undarlying Cousa (Disaasa or Injury that initiated avents rasulting in death) Last Myelodysplastic Syndrome Duelo (or es a consequence of): 23b. Did tobacco usa contributa to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Wera autopsy findings eveilabla prior to completion of causa of death? 24a. Was an autopsy performed?

Physician /Medicai Examiner

the

certificate

director,

The law requires that the deeth certificata be executed

P.O. Box 68760,

Records,

of Vital

Division

Hospital or Attending Physician:

24 hours efter deeth.

Funeral Director: After this filled in by the funeral

Physician

/Medical

Examiner

10a Stata

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7 is marked other than "natural", or items 23a or 28a-f ahow traumatic avent, the Modical Examinar must be motified at

Pages 1 and 2 should be filed within nent of Haeith and Mental Hygiena. int: If itam 27 is marked other than ' irry or other traumatic avent, the Ma

permit. Page Depertment of Important: If any injury or

filed within 72 hours efter deeth with the Maryland

21215-0020

Baltimore, Maryland

Examiner Physician/Medical Se esn sate has been signed by the ettal page 2 should be detached for by Be Completed Certification: To

Part II. Other algnificant conditione contributing to death but not rasulting in the underlying cause given in Part I.

25. Was casa rafarred to medical 1 Yas 2 No 27. Mannar of Death

5 Panding Investigation

6 Could not be datamined

Hospitel: 1 Inpatiant 2 ER/Outpatlent 3 DOA 28b. Tima of 28c. Injury at Work?

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

1 ☐ Yas 2 ☐ No

26. Placa of Death (Check only one)

Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a Cartified

1 Natural

2 Accidant 3 Suicida

4 Homicide

116 Certifying Physician: To tha best of my knowledge, daeth occurred at the time, date and place, and dua to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29b. Signatura and titla of certifiar

29c. Licansa number

29d. Data signed (Month, Day, Year)

of person who completed causa of death (Item 23a) (Type, Print)

Johns Hapkinstospita

State Registrar

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tificate of Death	Reg. No.	U	U	U	1	1

Physician
/Medical
Examiner

Funeral Director

the Marylend Pages 1 and 2 should be filed within 72 hours after deeth with the Manylen nant of Health end Mental thygiene.
and: If item 27 is marked other than "naturel; or items 23a or 23a-f show ury or other that matter ovent, I'm Medical Examine man to not item any or other that was one of the word. I'm Medical Examine man to not other that was one of the word.

permit. Page Department of Important: If any Injury or

Maryland 21215-0020

Baltimore,

Box 68760,

P.O.

of Vital Records,

Division

Physician /Medical **Examiner**

physician end the burial-transit attending p for use as 88

that the death certificate be executed ed by the a signed t Tha law requires page 2 should b After this certificate hes director funeral or Attending death. Director: A To the Hospital or within 24 hours after de To the Funeral Direct

Cel 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Year Month ZANE 98 - AYE 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Name (If not Institution, give street end number) mont ruse 6121 MON Home OC HCOM le gomet Bhthplece (State or Foreign Country)
 NJ If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 11,1910 6. Sex 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Min Months Deys Hours 1 □ M 2 🖾 F 87 Yrs. 109-03-8351 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10e. Stete 10c. City, Town or Location to Yes 2 □ No ROCKVILLE Director MD Montgomery 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 20852 United States 6121 MONTROSE ROAD by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2∑ No 11. Maritel Status 1 ☐ Never Married 2 ☐ Married Specify: White If Yes, Give Year or Detes: 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Abraham Malinoff Etta Rose 10 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 11012 Old Coach Rd, Potomac, MD 20854 (daughter) Eleanor Goode 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete 20e. Method of Disposition tery, cremetory or other place) 1 ☐ Buriel 2 ☐ Cremetion 3 ☑ Removel from State Mt Ararat Cemetery 2/13/98 Pinelwan, NY 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signature of Funerel Service Licensee Danzansky-Goldberg Memorial Chapels Inc 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

MD 20852

Approximate Intervel Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) ASPIRATION PNEUMONIA, RIGHT LOWER LOBE 24 HOURS Examiner MULTI-INFARCT DEMENTIA Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequenca of): Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy Completed performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Be 1□ Yes 2 No Hospital: To Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death
1 Naturel
2 Accident 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? edical Certification: 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mamar as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certif Attending Physician 18084 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

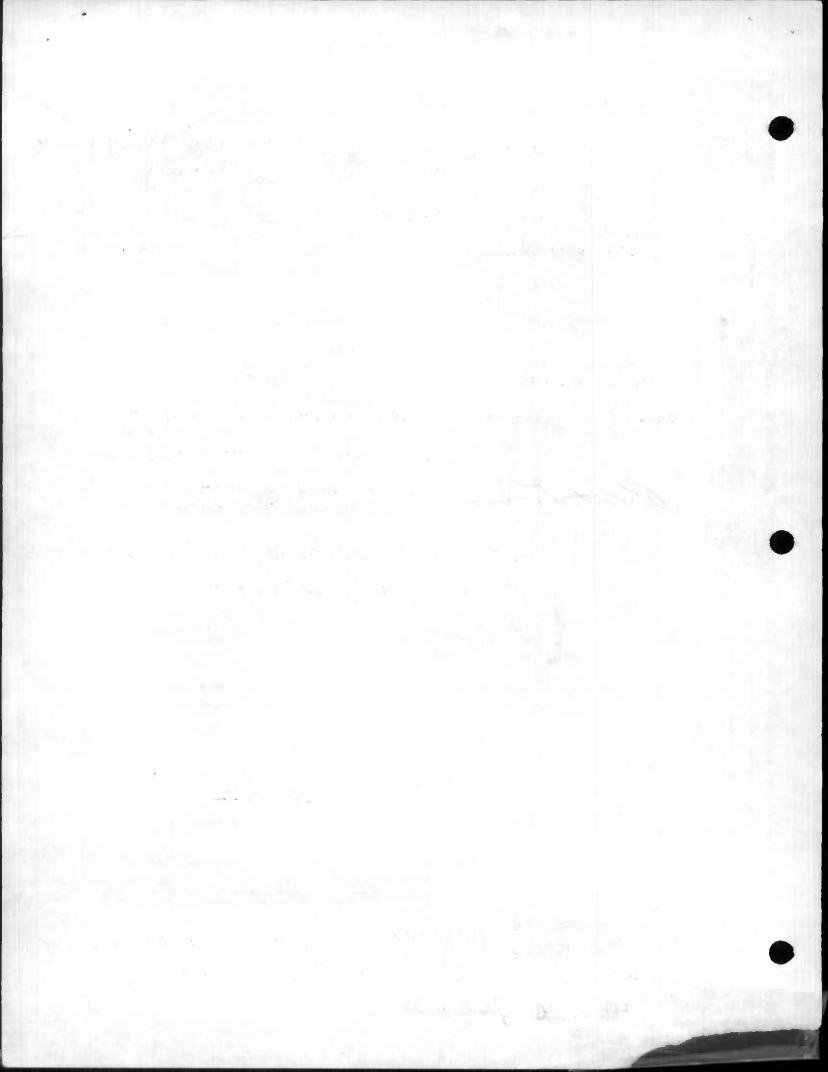
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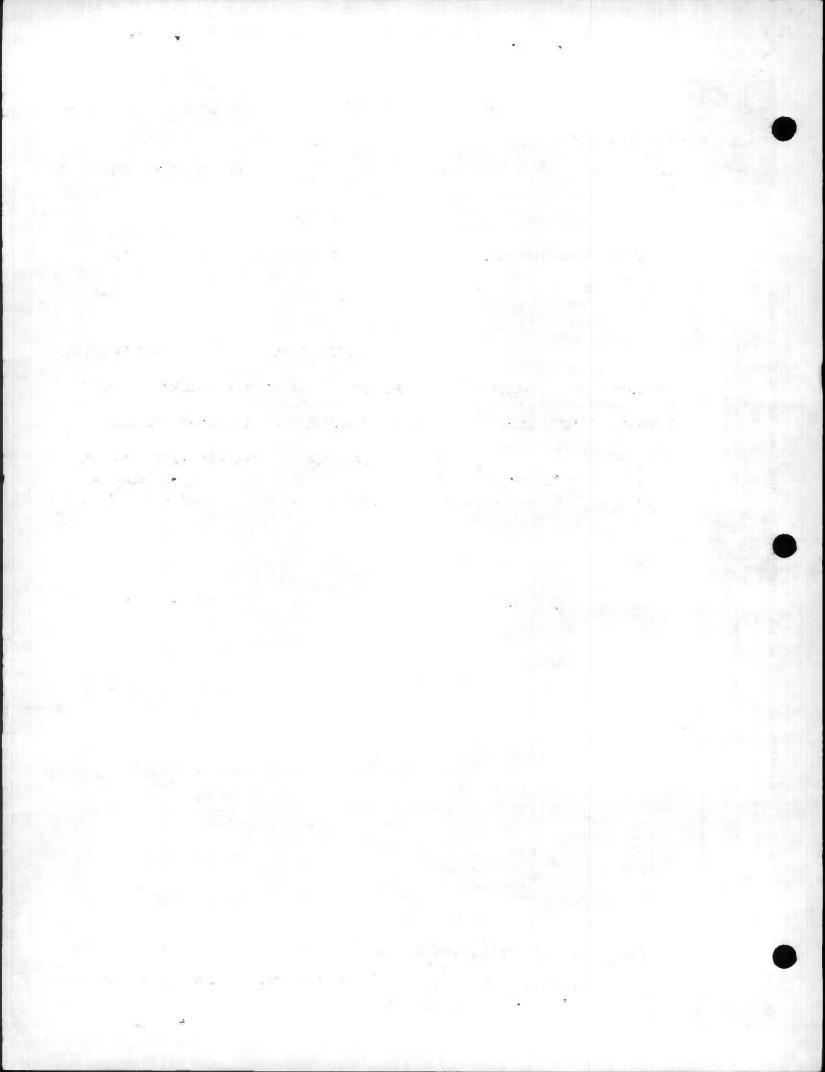
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ROGER ASHLEYItems	:23a part I,27 per MEO	G-757 3/25/98		tificate of			Reg. No.	069	16
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Funeral Director	5. Sociel Security Number 6. Security Number 157-42-9653	Mar of F	n yrs. lest birthdey) 44 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Da) OCT • 22	, 1953	9. Birthplece (S Country) NEW JER	SEY
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Dir De	10e. Street end Number	mov		10f. Zip Code	001		10g. Citizen of V		
ftar death w	27508 PEMBER	12. Was Decedent Eve	r in U.S. 13. \		801 lispanic Origin? (Sp	ecify Yas or No-		.S.A. e - American India	en,
	1 ☐ Naver Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yas 2 ☒ No ff Yes, Give Year or Detes:		_	lispanic Origin? (Spen, Mexicen, Puerto	Rican, etc.)	Specify	k, Whita, atc. WHITE	
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ind 2 sho alth and 27 is m	DEBORAH ASHLEY	•	6187				RY, MD		
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al or Attendi safter death Director: A d in by the fi	4 Homicida datarminad	28e. Placa of Injury building, etc. (5	- At homa, farm, str Specify)	eet, factory, office		28f. Location (8 City or Tov	otraat and Numb vn, Stete)	er or Rurel Route	Num <i>ber</i> ,
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	30. Name and address of person who constraints of the state of the sta	completed cause of death	h (Itam 23e) (Type,	Print) 111 Pen	n Street,	Baltim	ore, Ma	ryland 2	21201
State Registrar	Strphen S. 12 31. Date filed (Month, Day, Year) & MAR 05 1998	Gulla Day	Signatura Anglass						

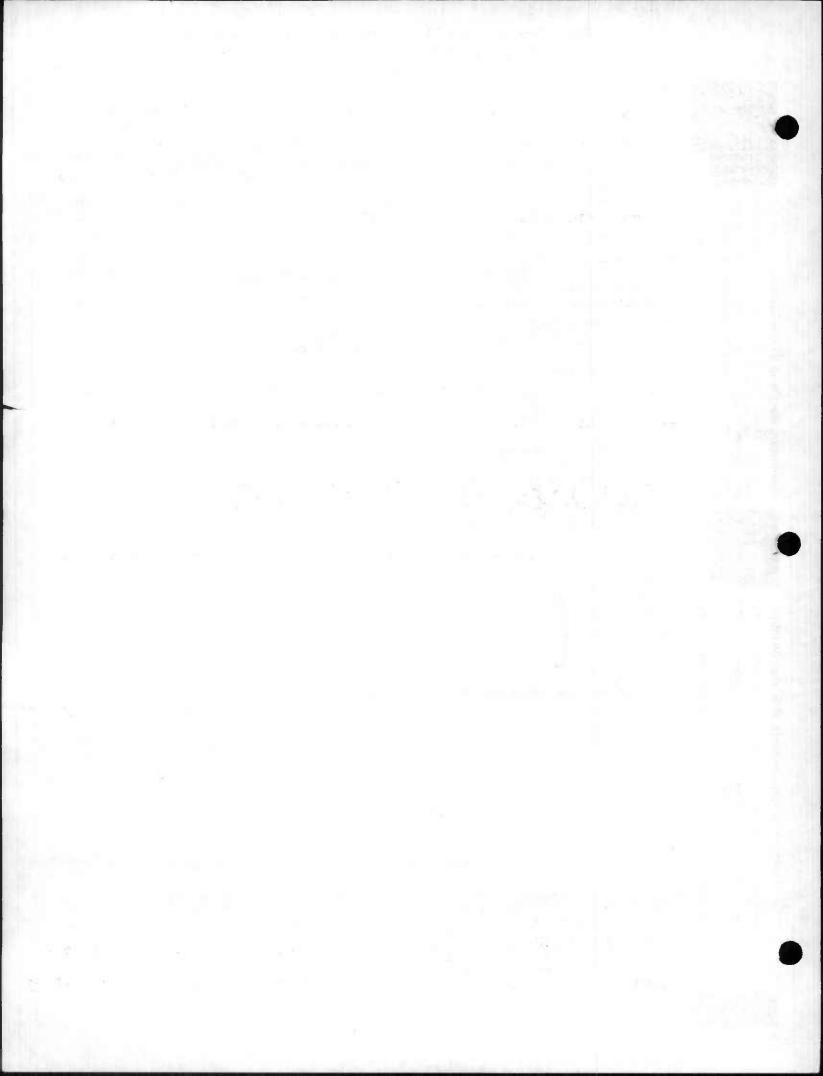
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		MARIO F. GOL	I JR M	N	3001	HOSP	ITAL	- DRIVE,	CHEVER	LY, M	4274	ND 20785

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Nama (First, Middle, Last) 2. Date of Death Breedlove Month Martha 5:30 A.N 1998 arel 4a. Facility Name (If not institution, give street 4b. City, Town, or Location of Death and number 4c. County of Death Good Samaritan Hospital Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) July 14, 1939 If Under 1 Year Months Days 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2X F Days 58 Yrs. 215-40-2430 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Timber Trail 21014 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes No Specify: Specify: White 3 □ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager/Vice President Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Frank Vincent Sterback Ruth Elizabeth Stinchcomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie C. Moxley/daughter 300 Market Street Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or othar place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 3/5/98 Baltimore, MD 21. Signature of Funeral Service License 22. Name and Addrass of Facility Dawn F. McDonald Cremation Society of Marylar 299 Frederick Road Baltimor shock, or heart failura. List only one cause on each line. Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onsat and Death Immediate Cause (Final disaase or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

The law requires that the death certificate be executed physician s the buriel esn page 2 s ial or Attending Physician: The offer death.

Softer death.

Director: After this certificated in by the funeral director, pt

Completed by Physician/Medical Be

Examiner Certification: To

Physician

/Medical

Examiner

Director

Funeral

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show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Ith end Mentel Hygiene. 27 Is marked other than " r traumatic event, the Wes

nt of Health e If Item 27 is or other tra

Department o Important: If any injury or

Physician /Medicai

Examiner

Peges 1 and 2 should be rent of Health end Mentel

the Maryland

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filed within 72 hours efter

21215-0020

Baltimore, Maryland

P.O. Box 68760,

Division of Vital Records,

27. Manner of Death

Medical

1 Natural 2 Accident 3 Suicida 4 - Homicide

29a. Certifier

5 Pending invastigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Dascribe how Injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

ammine

29d. Date signed (Month, Day, Year)

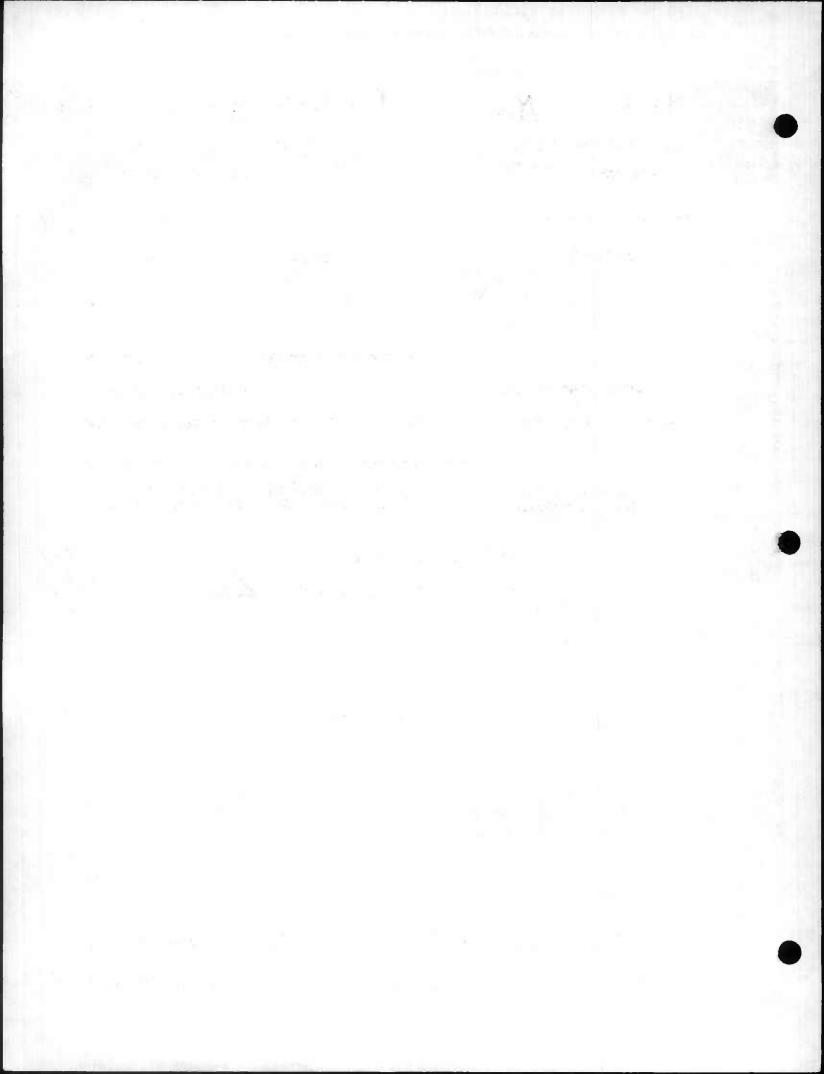
30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loch Raven Blud, Ballimore, 21239 AMMINE 5601 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar



with 24 You.
To the Funeral F



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death February 28 1198 9:00 AM John G 4e. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth c. County of Death Medical Center Baltimore 1 Derty If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (Stete or Foraign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 150M 20 F 217-24-2407 Yrs Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No NA attimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4663 61215 laware U.S.H 12. Was Decedent Evar in U.S. Armed Forcas? Race - Amarican Indian, Black, White, etc. Was Decedant of Hispanic Origin? (Spacify Yes or No-if Yes, specify Cuben, Maxican, Puarto Rican, atc.) 11. Merital Status 1 Navar Married 2 Married 1 ∀as 2 No If Yes, Giva Yeer or Detes: 1 Yes 2 No Black 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) Collega (1-4or 5+) Fork Lift Driver unknown 9th grade NA 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Barnes Wynn Conger 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 2312 Madison Lhenue Ba Ho, My 20a. Malbod of Disposition 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, Stata Date 1 Burial 2 Cramation 3 Ramoval from State 4 □ Donation 5 □ Othar (Specify) 21. Signature of Funaral Service Licensee 71215 K renne Balto, nd War Wabas 23a. Part1. Enter tha disaasa, or complications that causad tha daath. Do not enter the moda of dying, such as cardiac or respiratory errast, shock, or haart failura. List only one cause on aech lina. 300 Approximete Intarval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting In daath) Dua to (or as a consequence of) Hupotenois Dua to (or as a consequence of): metartatic Mortale Carcer Dua to (or as a consequence of): piratiru tailure Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760

The law requires that the death certificate

Attanding Physician:

signed by the a id be detached f

page 2 s

certificate

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Attor

if or Atland after death Director:

To the Hospital or within 24 hours aft To the Funeral Di completely titled it

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Certification: To

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permit. Pages Department of important: If it any injury or o

Physician

/Medical

Examiner

10a. Stata

Md

Funeral

Director

rel', or items 23a or 26a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene.
wit: If item 27 is marked other than "naturel; or items 23, my or other traumatic event, the Medical Examine mail.
mry or other traumatic event, the Medical Examine mail.

Director

Funeral

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Examiner Sequantially list conditions, if any, laading to immadiete causa. Enter Undarlying Ceusa (Diseasa or Injury thet initiated evants rasulting in death) Lest Physician/Medical guipuette

24a. Was an autopsy performed? 1 Yas 2 No

24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yas P No

25. Wes casa rafarred to medical axaminer? 1 Yas , 2 No 27. Manner of Deeth

26. Placa of Death (Check only ona) Hospital. Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 ER/Outpatient 3 DOA 28a. Deta of tnjury (Month, Day Yaar) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred

1 Natural
2 Accidant 3 Suicida 4 Homleide

5 Panding Invastigation 6 Could not be datarmined

30. Nama and address of person who complated causa of daath #tama23a) (Type, Print)

1 ☐ Yas 2 ☐ No 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

29e. Certifian

Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

Madicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

medical

29b. Signature end titla of certifiar J. fanton.D Terance

29c. License number

Center

Baltimore

29d. Data signed (Month, Day, Year) February 28th 1998

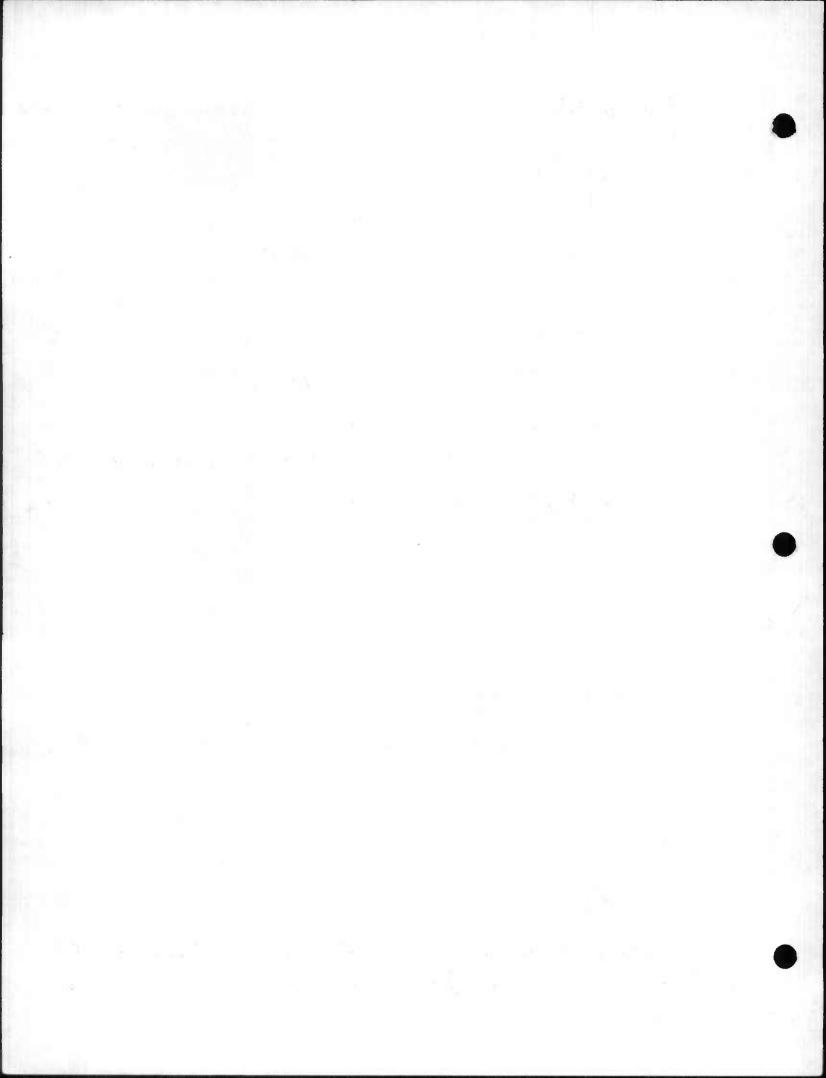
State Registrar

Teronce LAMB 31. Data filed (Month, Day, Yaar)

MAR 05 1998

Luberty 32. Ragistrar's Signatura

relie Davidson-Randall



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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

DIONNE BROOKS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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No	10	U	U	1	4	U	

4
Physician
/Medical
Evaminer

1. Decedent's Name (First, Middle, Last) 4a Facility Name (If not Institution, give street and number)

2. Date of Death Month FEBRUARY

3. Time of Death 3:18P.M.

LAUREL REGIONAL HOSPITAL

Director

Funeral

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Completed

Be

4b. City, Town, or Location of Deeth

27,1998 4c. County of Death

PRINCE GEORGES

10g. Citizen of What Country?

Funeral Director

item 27 is marked other than "naturel", or items 23s or 28s-f show other traumetic event, the Medical Examiner must be notified at

2 should be filled within 72 hours effer end Mentel Hygiene. Is marked other than "naturel", or its

permit. Pages 1 and 2.
Department of Health et
Important: If item 27 Is
eny injury or other trau

Baltimore, Maryland 21215-0020

the Marylend

with 1

death

5 Social Security Number 13-86-900 Usual Residence of Decedent 10b. County

7. Age (In yrs. last birthday) Months 1 M 2 F Yrs.

If Under 1 Year If Under 24 Hrs. Deys Hours

LAUREL.

8. Date of Birth Birthplace (State or Foreign Min.

10a. State Maryland

10e. Street and Number

10c. City, Town or Location

more 10f. Zip Code

10d. Inside City Limits Ves 2□No

26 11. Maritel Stetus

1 Never Married 2 Married

Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Dates: 12

(mother)

13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

Ver

3

14. Race - American Indian. Biack, White, etc.

3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired).

2

ttro 16b. Kind of Business/Industry

Elementary/Secondary (0-12) -17. Father'a Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumeme,

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code

19a. Informant's Name/Relationship (Type, Print)

20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

20b. Plece of Disposition gemetery, crematory Gardens

or Town, State

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses

0 22 Z AUR Nor 23u Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, which, or heart rejure. List only one ceuse on each line.

22. Name and Address of Facility

Approximate therval Between Onset end Death

Physician /Medical immediate Ceuse (Final disease or condition resulting in death) **Examiner**

88

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After

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To the Hospital
within 24 hours e
To the Funeral Hospital

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Records, P.O. Box

Division of Vital I Attending Physician: Examiner

Physician/Medicai

by

Completed

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Certification:

Medical

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

Hanging Due to (or as a consequence of):

Due to (or as e consequence of):

Due to (or as e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

1 Yes 2⊠ No

26. Place of Death (Check only one)

24b. Were autopsy findings evailable prior to completion of cause of death?

1 X Yes 2 □ No

28d. Describe how injury occurred

24a. Was en eutopsy

1 Ves 2 No

25. Was case referred to medical examiner? TXXYes 2□ No

27. Manner of Death

1 Naturei

2 Accident

3 Sulcide

4 Homicide

5 Pending

Investigation

6 Could not be determined

28a. Date of Injury (Month, Dey Year) 2-27-98 1400

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 2.PKNo 1 Yes

Ligature hanging
281. Ocation (Street and Number of Bural Route Number,
City or Town, State) House of Connection Corrections

(Check only one)

| Woman's House of Corrections Jessup, Maryland

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XMedical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

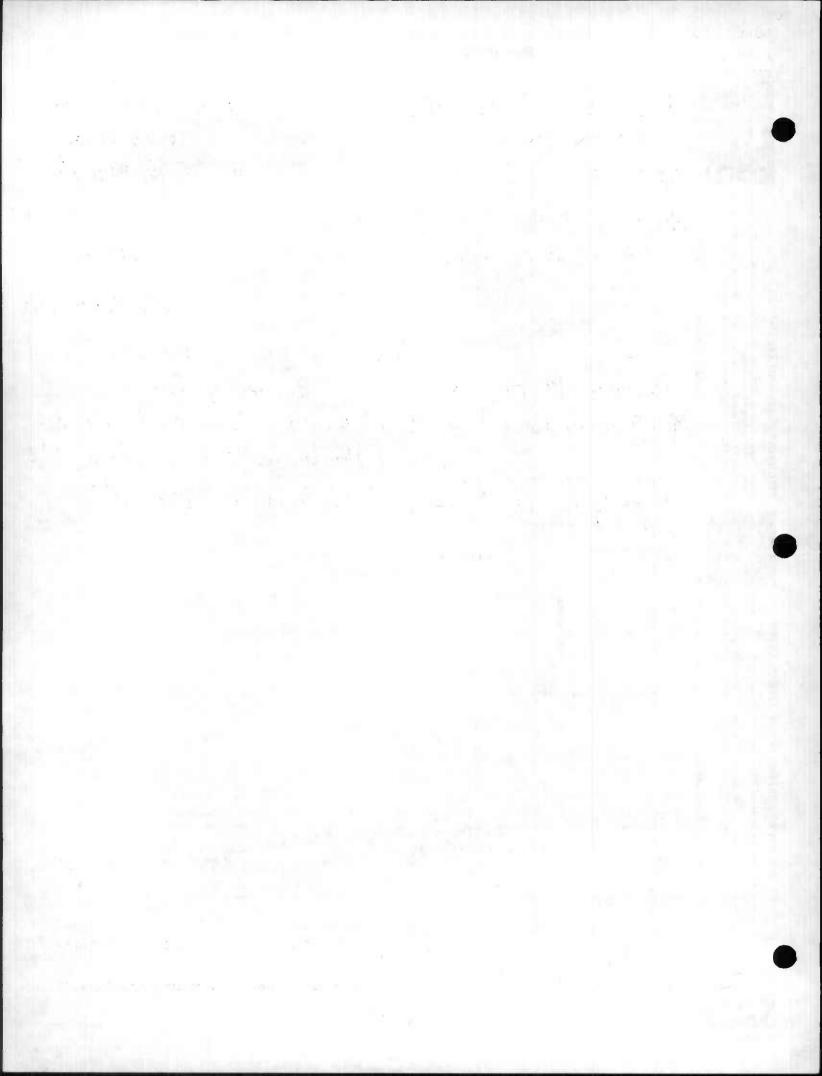
FEBRUARY 28,1998

Stephen S, 31. Date Hied (Month, Day, Year) Radentz MP 111 Penn Street, Baltimore, Maryland 21201

State Registrar

MAR 05 1998

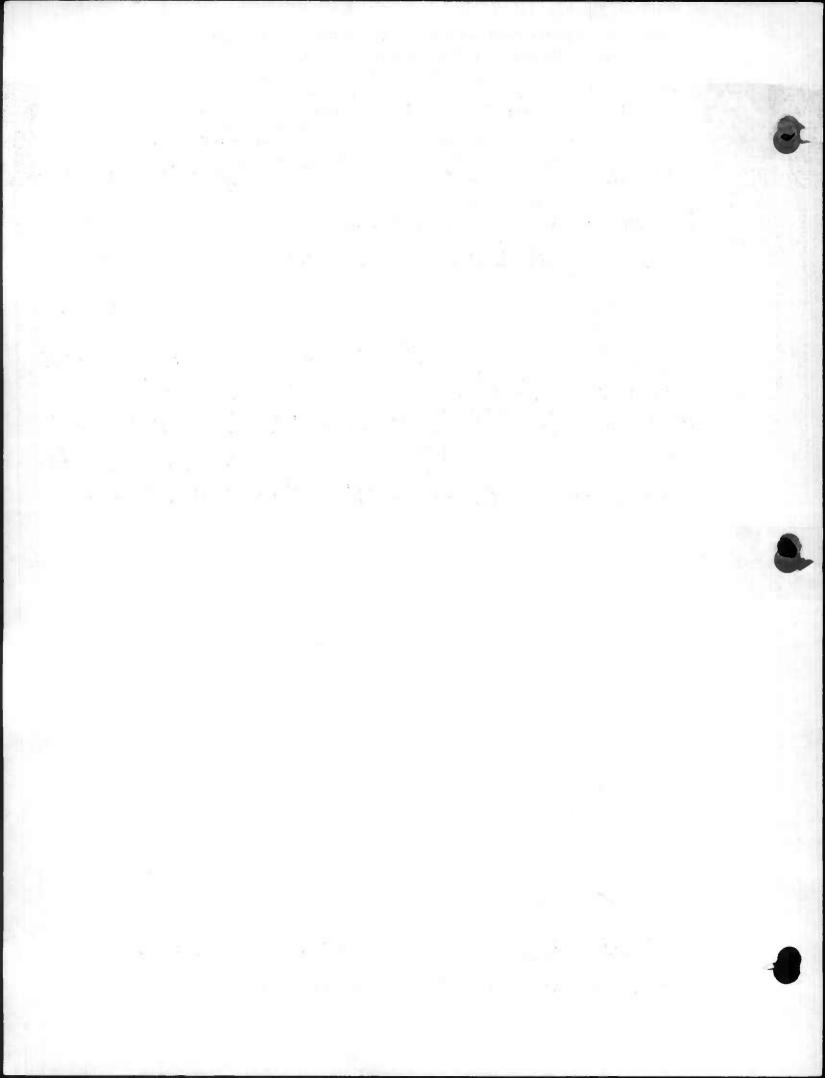
32. Registrer's Signature the Davidson-Randoll



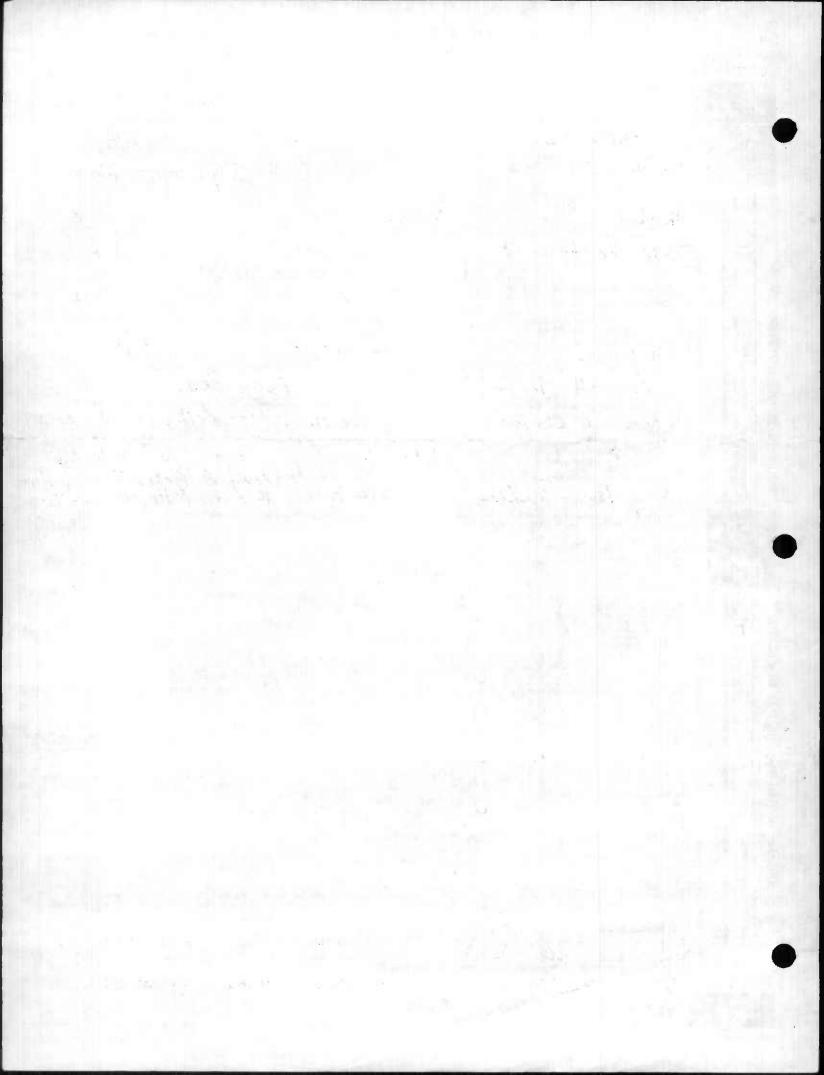
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Marylar		ate of Death		3. No.	3 069	921
		т	1. Decedent's Name (First, Middle, Last)	1	D	1	2. Dete of Deeth			ime of Death
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10	Exami		4e. Fecility Neme (If not institution, give		10 00-110-0		Location of Death	4c. County		
-			VILLA ST MICH			1	ALTIMORE	N/		
	Funeral Director		5. Sociel Security Number 6. Sec. 121-30-0052	7. Age (In yrs	Yrs. Month	der 1 Yeer if Under 24 Hr ns Deys Hours Mir		1933	9. Birthplace (:	State or Foreign
	hend was		10e. Stete 10b. County	10c. C	ity, Town or Location				10d. Ins	side City Limits
	Many First	ō	Maryland N/A		Baltin	nore			1,0	¥Yes 2□No
	or 28	Director	10e. Street end Number	1, 1		Zip Code	10	g. Citizen of y	What Country?	
	23a c	Je J	1 Sudbroo	K Lane		21208		4	15 A	
	toms	Funeral		12. Wes Decedent Ever in L Armed Forces?	J,S. 13. Wes Dec if Yes, sp	cedent of Hispenic Origin? (pecify Cuben, Mexican, Pue	Specify Yes or No- into Rican, etc.)		e - American ind ck, White, etc.	ian,
20	ours efter death with the Maryler al, or items 23a or 28a-f show Evaniner must be notified at	by F	1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 10 No If Yes, Give Yeer or Detes:	1 ☐ Yes	2 No Specity:		Specify	5. No.	
9	n 72 hours "natural",		15. Decedent's Educ	cation	16e. Decedent's U:	suel Occupation	10	5b. Kind of Bu	U - MM	erican
215	d within 72 h jiene. r then "natu tre Medical	plet	(Specify only highest grede Elementery/Specification (0-12)	completed) College (1-4or 5+)	(Give kind of the DO NOT	work done during most of w Tuse retired)	orking	1	,	/
21	ed withir ygjene. er then t, the M	Completed	12		Hom	emaker	•	OU	un h	ome
Maryland 21215-0020	and 2 should be filed within 72 hours efter death with the Maryland eath and Mental Hygiene. 27 is marked other than "natural", or ferms 23s or 28s-f show ner traumatic event, the Madical Examiner must be northed as	Be	17. Father's Neme (First, Middle, Last)	Bucton		18. Mother's No	eme (First, Middle, M	olden Sumem	10)	
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ē.	f Healthern Stem Stem Stem Stem Stem Stem Stem Stem		20e. Method of Disposition		Plece of Disposition (A	Verne of	pete 2	Oc. Location -	City or Town, S	lete
E	Peges nent of h int: If ite		12 Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	emovei from State	MEZI	()	3/5/98 /	nns	douine	· Md
Baltimore,	permit. Peges 1 and 2 to Department of Health er Important: If Item 27 is any Injury or other trauonce.		21. Signature of Funerel Service Ocense	000	Colores Colores	end Address of Fecility			11	71101
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			23a. Part1/Enter the disease, or compile shook/or heart failure. List only on	cations that caused the dea	th. Do not enter the m	node of dying, such es cardi	ac or respiretory erres	st,	Approinten	oximete val Between
	Physician		U						Onse	et end Deeth
4	/Medical Examiner		immediete Ceuse (Finel diseese or condition resulting in death)	TERMINAL	VAGINAL	CANCER			3 N	ionths
		<u>ē</u>		Due to (or es e consequenca o	of):				
92	ansit d	Examiner	Sequentially list conditions	Due to (or es e consequence o	of):				
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000	law re las be	ple	ANOXIC ENLEPHA	1.0P/1 (17 Y					completi of death?	on of cause
2 4	sician: The law certificate has b lirector, pege 2 s	Con	INSULIN DEPENO	ENT DIABETE	5		1 ☐ Yes	2 10	1 ☐ Yes	2□ No
BURTO n of Vita	ysician: s certific director,	Be	25. Wes case referred to medical exeminer?	ospitel:		0.0	eeth (Check only one			
UR	Phys ral di	. To	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ 28b. Time of		Home 5 ☐ Residen			
0 60	Attanding Physician: r death. ector: After this certifici by the funeral director,	tion	1 Netural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Dey Year)	Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No		,,		
BURTON OLIVIA	or Attandin safter death. I Director: Af d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of injury - At h building, etc. (Speci	nome, farm, street, fect	ory, office	28f. Location (Stre		per or Rurel Rout	e Number,
Ö	rs after or all Dir	Cer	45110111000	building, etc. (Speci	197		Only or Young	01010/		
	To the Hospital o within 24 hours at To the Funeral DI completely filled in	edical	(Check only 2 Madical Examin	er: On the basis of examine	owledge, death occurre	ed et the time, date end plea on, in my opinion, deeth occ	ca, end due to the cau	ise(s) end me	enner es steted. end due to the c	euse(s)
	within 2 To the P	Med	one) 29b. Signeture end title of certifier	end manner stated.		29c. License number			d (Month, Dey,)	· -
	7 × 5 8	-	1 alman la la			H4593/		_	2, 1998	sout)
			30. Name end eddress of person who co	moleted cause of death (ite	m 23a) (Turno Print)	וטוטדיו	/	iui ori	V11110	
	2			1611TS AVENV		ZTIMONE, M.	D SIAN	8		
	Sta	ite	31. Dete filed (Month, Dey, Year)	32. Registrer's Sign						

DHMH 16 Rev 6/95

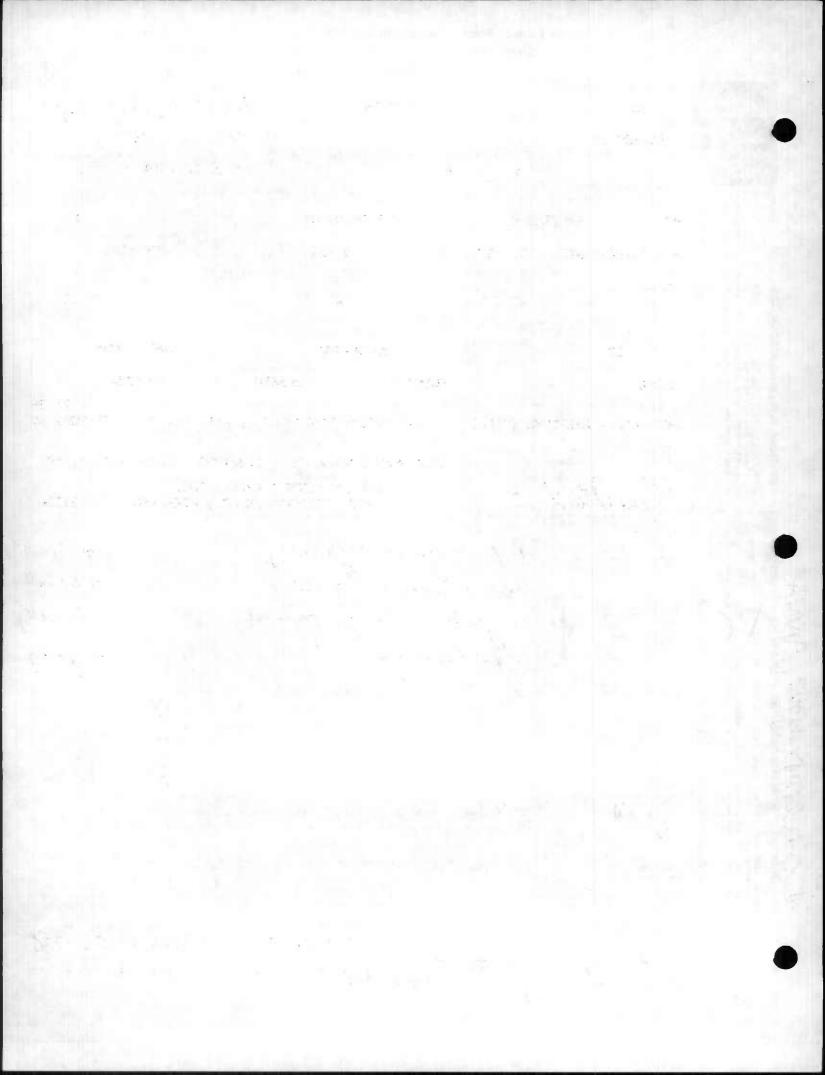


98-1030-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. ihm State of Maryland / Department of Health and Mental Hygiene MARY ALICE BUTLER Items: 23a 8 Per FH Film G-757 3/18/98 dh Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month Pay 26' 1998 Mary **Physician** 05:08 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, giva straat and number) 4c. County of Death Examiner 572 PRESSMAN STREET BALTIMORE 8. Data of Birth Mopth, Dey, Yeer If Undar 1 Yaar If Undar 24 Hrs. 9. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 219-40-2697 **Funeral** 1□M 25F Deys Hours 53 Yrs. Director Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits item 27 is marked other than "natural", or items 23s or 28a-f abov other traumatic event, the Modical Examiner must be notified at Battimore 1 Yes 2 No Maryland Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Prestman 21217 572 238 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Detes: iteme Wes Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: If flem 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Elementance. 1 Never Married 2 Married Black 1 Yes 2 No Specify: altimore, Maryland 21215-0020 þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementery/Secondary (0-12) College (1-4or 5+) unemployed 11th Grade 18. Mothar's Neme (First, Middle, Meiden Sumeme) 17. Fathar's Neme (First, Middle, Last) Be reesevell tossie Bear 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Baltimery roxanne 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service License 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting In deeth) /Medical FATTY LIVER Examiner Due to (or es e consequence of): Physician/Medical Examiner attending physician and for usa es the burlet transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): 80 signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yss 2 ☐ No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of causa of deeth? Completed 24e. Was en eutopsy should pege 2 has 1 PYes 2 □ No 1 Yes 2 No certificate or Attending Physician: director. 25. Was case referred to medical axaminar? Be 26. Plece of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 🐧 ☐ Residence 6 ☐ Other (Specify) To 1X Yas 2□ No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28e. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. injury et Work? Certification: After 1 Waturel 5 Pending investigation aftar death. 1 Yes 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medicai within 24 hor To the Fune completely fi (Check only one) Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) OCME FEBRUARY 26, 1998 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) w br lawid 111 Penn Street, Baltimore, Maryland 21201 Date filed (Month, Day, MAR 0 5 199 State Registrar



Item: 11 Per FH Film G-757 3-5-98RC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Physician //Accided Examiner Funcial F		State of Maryla	and / Department of I	Health and Mental H	ygiene Reg. No. 98 06923
EXAMINE Examiner Leverity Name of the detailed on previous part of the details of previous part of the details of the previous part of the details of the previous part of t		ANINA	BAREMBOYM		Deeth 3. Time of Death
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Figure 1 Figure 2	020 urs after elf, or its	3 ☑ Widowed 4 □ Divorced If Yes, Give A Year or Dates:			
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MRS. NOEMA AVERBUKH (DAUG) 20e. Menhod of Disposition All Burial 2 Commission 3 (Removed from State 4 (Donation 5 Comber (Specify)) 20e. Menhod of Disposition All Burial 2 Commission 3 (Removed from State 4 (Donation 5 Comber (Specify)) 21. Signature of mental series (Laboration 5 Comber (Specify)) 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISPERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISPERSTOWN RD. PIKESVILLE, MD 21208 Approximate relevant Between Orbital and Bearing Commission Physician Physi	uld be filed Aental Hyg rked other tic event,	17. Father's Neme (First, Middle, Last) MOSHA	KOYTICH		
Physician Medical Examiner 23a. Fig. 1. Empt the disease of obtinglications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest. Approximate Approximate Approximate and solving of the cease of each line. Due to (or es a consequence of):	ore, North of Health	MRS. NOEMA AVERBUKH (DAUG) 20a. Method of Disposition MD Burial 2 Defendation 3 Demoved from State	A19 VALLEY M Place of Disposition (Name of cemetery, cremetory or other ple	EADOW CIR., APT	A-4 REISTERSTOWN, MD
24a. Wes en eutopsy performed? 1	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest	(or es a consequence of): (or es a consequence of): (or es a consequence of):	ing, such as cerdiac or respiratory cency uluse fullure	errest, Approximate Interval Between
24a. Was en eutopsy performed? 24b. Were eutopsy indings available prior to completion of cause of death? 1			1/		
25. Was cese referred to medical examiner? 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one)				ре	nformed? available prior to completion of cause of death?
30. Name and address of the on who completed cause of deeth (Item 23a) (Type, Print) by Schredule are Bulk most -	DIVISION Of VIEW Houpital or Attending Physician: A hours after death. Funeral Director: After this centification by the funeral director. Iteal Certification: To Be	25. Was cese referred to medicel exeminer? 1	28b. Time of Injury Month of I	26. Plece of Deeth (Check only ther: 4 Nursing Home 5 Re larger to the control of	sidence 6 Other (Specify) a how injury occurred (Street and Number or Rural Route Number, own, Stete) ie cause(s) end manner es steted. e, date and piece, and due to the cause(s)
State 31. Date filled (Month, Dey, Year) 32. Registrar's Signature	3 State	31. Date filled (Month, Dey, Year) 32. Registrar's Signary	2434 W Sunature	medica ane	-, Buckmose -



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filed within 72 hours after

Baltimore,

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene G-757 3/5/98 rep of Death Reg. No. Items: 23 part I,27 1. Decedent's Neme (First, Middle, Lest) 2. Date of Deeth 3. Time of Deeth **Physician** 25, 1998 1907 PM FEB. DEBORAH O. BERNARD /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner UNIVERSITY HOSPITAL E.R. BALTIMORE N/A If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) If Under 1 Year 5. Sociel Security Number Birthplace (State or Foreign Country) 6 Sex **Funeral** Months Days 1 ☐ M 2 🛱 F Yrs. 41 3/22/57 Director 214-68-3958 MARYLAND Usuel Residence of Deceden 10a Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits 15 Yes 2 □ No Directo MD BALTIMORE N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6818 HARFORD ROAD 21234 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☐ Xo 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ If Yes, Give Year or Detes: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) permit. Pages 1 end 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na eny injury or other traumatic event, the Mental page. Elementary/Secondery (0-12) College (1-4or 5+) 12 -0-CLERK FOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORRIS BERNARD SERITA BRACCO 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ANTONIO WILKINS (SON) 900 ARGYLE AVE. - BALTIMORE, MD 20b. Pleca of Disposition (Neme of cemetery, crematory or other plece) Date 20c. Location - City or Town, State 20a. Method of Disposition Buriel 2 Cremation 3 Removal from State KING MEMORIAL PARK 3/3/98 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servica Licenses ELIZABETH L. PHILLIPS 1721-27 N. MONROE ST.-BALTO., MD 21217 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical a. NARCOTIC INTOXICATION Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Was en autopsy Completed 1 Yes 2 No 19 Yes 2 □ No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) XXYes 2 No Hospital: 1 ☐ Inpatient 2KX P/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 28b. Time of found M found 7:07 28d. Describe how Injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 No Unknown
28f. Location (Street end Number or Rurel Route Number,
City or Town, Stete) Baltimore, Md. 2 Accident 2/25/98 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide

physician and s the bunal-trans certificate be axed Box 68760 98 950 Po ed by tha a P.O. signed by t Records, peen has Division of Vital shis funeral After or Attending after death. 2 24 hours a To the I within 2

29a. Certifie (Check only one)

4 ☐ Homicide

29c. License number

found at 700 Blk Brune St. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature end title of certifier

MAR 05

O.C.M.E

29d. Date signed (Month, Day, Year) FEB. 26, 1998

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

Unknown

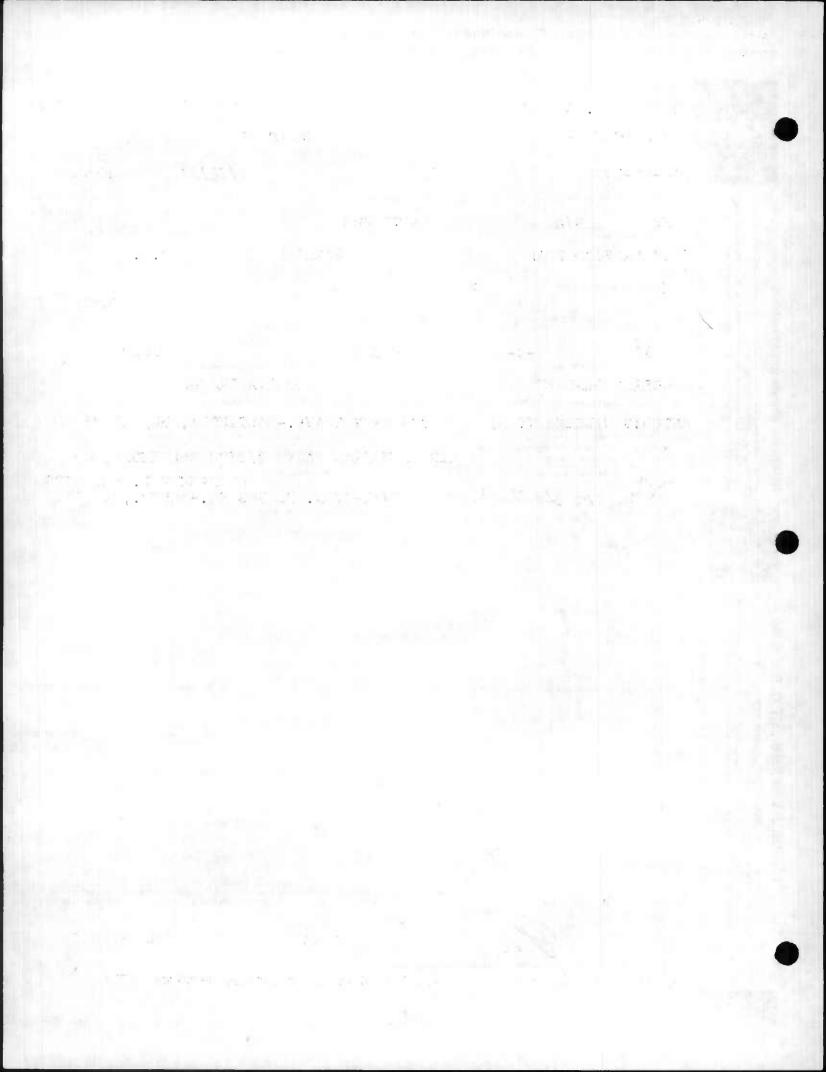
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1998

22. Registrer's Signature whe Savidson-Random

State Registrar

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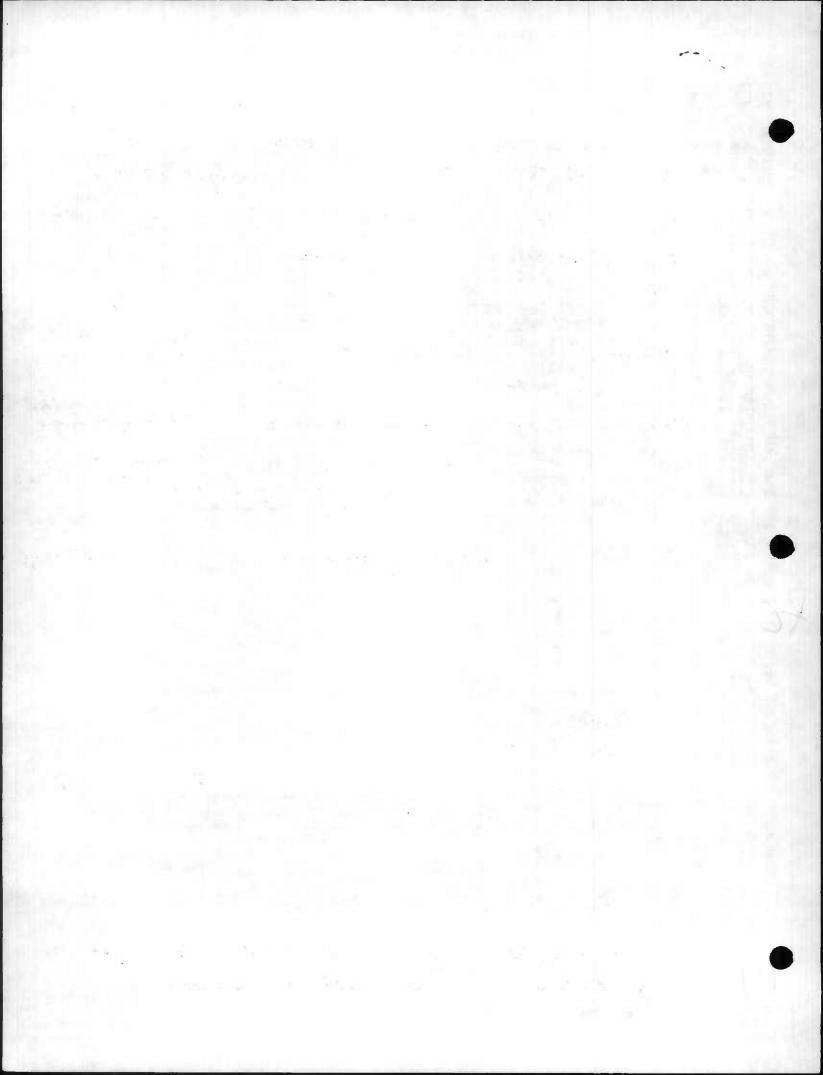
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2353 TYRELL CORBERTT 25 February 1998 /Medical 4a Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Hopkins Bultimore H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Deys Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Aga (In yrs. lest birthday) 214-96-4432 Months M 2DF Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. insida City Limits 28a-f show r is marked other than "natural", or items 23s or 28s-f show traumatic event, the Wooles Examinar must be notified at Nas 2□No BALTIMIR Directo Mary Aus 10f. Zip Code 10g. Citizen of What Country? 241 1637 STYEET Funeral 11. Marital Status Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Datas: natural, or 1 Yes 2 No by 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry George W. F. Hc Mach permit. Pages 1 and 2 should be filed within: Department of Haelth and Mental Hygiena. Important: if item 27 is marked other than "r Elamantary/Secondary (0-12) College (1-4or 5+) High ScHOI grade 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Catherine SAUOY CORBERTY 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 3/3/8 19a. Informant's Name/Reletionship (Type, Print) Boltinere, nerylons MUTHER 2543 GrEENMOUNT 20b. Place of Disposition (Name of cematary, crametory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Bunal 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) AVBUTUS Marylows MEMORIAL/ATE 22. Nama and Address of Facility CHATMAN HAM'S FENERAL HOME 21. Signature of Funeral Service License BATINOIC, HID 21215 23a. Part1. Entof the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failura. List only one causa on each line. Approximata Interval Between Onset and Death Ph sician /Medical Immediate Cause (Final disease or condition resulting in death) 25 days Necrotizing Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Causa (Disease or Injury that initiated avents resulting in death) Last ettending physician end for use as the buriel-tran Due to (or as e consequence of): P.O. Box 68760. Dua to (or es a consequence of): SI signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yae 2 No 3 ☐ Probably 4 ☐ Unknown Sepsis Q 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Renal failure 1 □ Yes 2 No certificate ardine or Attending Physician: 25. Was case refarred to medicel axeminer? 26. Place of Daath (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 10 this funeral 27. Mannar of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: After 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 1 Yas 2 No 6 Could not be detarmined 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide edicai Cartifying Phyeician: To the best of my knowledge, death occurred et the time, data and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, data and place, and due to the cause(s) and menner stated. 29a. Cartifier (Check only one) 29b. Signatura and title of certifiar 29d. Data signed (Month, Day, Year) DO0 51551 February 27, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Wolfe St.

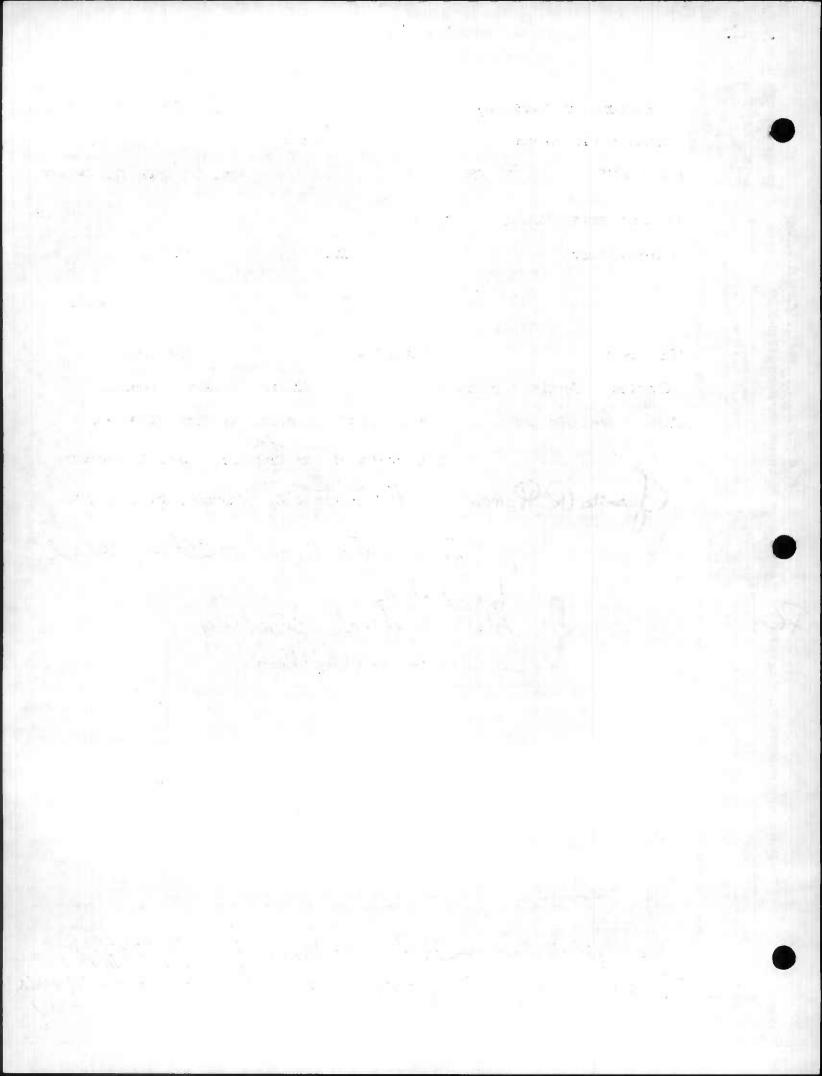
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Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 16926

	Certificate	e of Death	Re	g. No.	7 2 4 0
Dhuninian	1. Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month	n Dev Year	3. Time of Death
Physician /Medical	Katharine P. Daughaday		2	28 1998	12:38 A.
Examiner	4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or L	ocation of Deeth	4c. County of Death	
	Lorien Nursing Center	Belcamp		HARF	ORD
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Dey,	Year) 9. Birthr	place (State or Foreign htry)
Director	137-30-1249 1 M 2X F 85 Yrs. Months		Nov. 19	, 1912 New	Jersey
	Usual Residence of Decedent				
show ad at	10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits 1 ☐ Yes 2 🛣 No
rottled at	Maryland Harford County Bel Air				
or 2	10e. Street and Number 10f. Zip			og. Citizen of What Coul	ntry?
23a rail	23 13233 2213	1014		U.S.A.	
r items 23s or 28s-f solrest must be notified Funeral Director	11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent Ever in U,S. If Yes, specific Yes, yes, yes, yes, yes, yes, yes, yes, y	lent of Hispanic Origin? (Sp cify Cuben, Mexican, Puerto	ecity Yes or No-	14. Raca - Americ Bleck, White,	
or h	1 Never Married 2 Married 1 Yes 2 No			Specify:	
Example 1	3 ☑ Widowed 4 □ Divorced Yeer or Detes:			W	hite
the material, it is made a second	15. Decedent's Education 16e. Decedent's Usua (Specify only highest grade completed) (Give kind of wor	al Occupation rk done during most of worl se retired)	kina	16b. Kind of Business/In	dustry
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So F	12th Grade Homemaker			Own Home	
9 9	17. Father's Name (First, Middle, Last)		ne (First, Middle, N		
To affic	Charles Curtis Pritchard	Ellen	Louise	Denison	L
other traumatic		(Street and Number or Ru			
27 is marked or traumatic ex TO E	Ellen E. Howie/Daughter P.O. Box 4	0, Altamont,	New Yor	k 12009-004	.0
E &	20a. Method of Disposition 20b. Place of Disposition (Nancemetery, crematory or o	ne of ther place) 3/3/98	Date 2	20c. Location - City or To	own, Stete
= 0	1 Burial 2 Acremetion 3 Removal from State 4 Donation 5 Other (Specify) Baltimore/Was			Laurel, Mar	vland
any injury				•	-
Important: any injury once.	John C.	Address of Facility Miller, Inc			21226
		lair Road, B			Approximate
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rector, page 2			1 □ Y€	-	□Yes 2□No
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director.	25. Wes case referred to medical examiner? Hospital:	Other: 1	th (Check only on		
90	1 Impatient 2 En/Outpatient 3 ID	DA 4 Nursing H		ence 6 Other (Speci ow injury occurred	Ty)
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rtifi	3 Suicide 4 Homicide 6 Could not be determined 28e. Ptaca of Injury - At home, farm, street, factory building, etc. (Specify)	/, offica	City or Town	reet and Number or Rur n, State)	ar moule Number,
S S					
pletaly fil	29a. Certifier (Check only 2□ Medicat Examiner: On the basis of examination and/or investigation,	at the time, date and placa, in my opinion, death occu	, and due to the ca	ause(s) and manner es : ate end plaça, and due !	stated. to the cause(s)
To the Funeral Director: completely filled in by the Medical Certifical	one) end menner stated.				
E com	29b. Signature and title of perilifier	. License number	/ 2	9d. Date signed (Month,	Day, Year)
	TIME LUID.	12066	(4287	XX
4	30. Name and address of person who completed cause of death (year 33a) (\$75c, Print)		I M	1-06	1%
-	TTT GEMIN LLY DOLLA	Ation S	1 let	TUNDANO	-67NO4
-	3 Seate filed (Month, Day, Year) VI 32. Registrar's Signature	mru -	1 - W	1000	1010
State	MAR 05 1000 Fisher Raydon Randolle				1000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month ANNIE EVANGE 21STA 1:051 03 1998 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth ed ei If Under 1 Yee 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Undar 24 Hrs. 8. Dete of Birth 9. Birthpiece (Steta or Foreign Months Deys 218-03-8660 1□M 2 F Hours Usuel Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Maryland 1. Yes 2 □ No MOY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 02 12. Wes Decedant Ever in U,S. Armed Forcas? 14. Race - Amaricen Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritai Status 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yas, Give 1 ☐ Yes 2 ☑ No Specify If Yas, Give Yeer or Detes: 3 Widowed 4 □ Divorced Ne 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College:(1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) 19e. informent's Name/Reletionship (Type, Print) Guardian 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zig Code) 20b. Place of Disposition (Neme of 20e. Mathod of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete cemetary, cramatory or other place Nationa 21. Signature of Funaral Sarvice Licensea 22, Nama and Addrass of Facility Joseph 23e. Part Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cerdiac or raspiretory errest, shock, or heart fellings. List only one ceuse on each line. North Ave. Approximete intervel Between Onset and Deeth immediate Ceuse (Finel disaasa or condition resulting in death) STAPH. SEPSIS WK. FAILURE 11 KEART ESTIME Dua to (or es e consequenca of) MEARD DISEASE UNKNINN ARTERIOSCLEROTIC Dua to (or as a consequance of) 23b. Did tobacco uss contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Bilatural 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? HYPERTENTION DIABETES MELLITUS 1 Yes 280 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

signed by the a d be detached f

page 2 has

funeral director,

filled in by

completely

certificate

After this

death.

after death

24 hours a Hospital

within 2

or Attending Physician:

by

Certification: To

edical

Physician

/Medical

Examiner

Funeral

Director

ral', or items 23a or 28a-f show Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter death v
Department of Heelth and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or forms 23a
any injury or other traumatic avant, the Med

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

Director

Funeral

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Completed

Be 0

with the Meryland

Physician/Medical Examiner attending physician and for use as the burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be-88

Pert if. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f.

5 Panding investigation

6 Could not be

28e. Pleca of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

26. Piece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify)

28d. Describe how injury occurred

25. Wes case referred to medical exeminer? 1 Yas 2 No 27. Menner of Deeth

28a. Dete of injury (Month, Dey Year)

14☐inpatiant 2☐ER/Outpatient 3☐ DOA 28b. Tima of fnjury

28c. injury at Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)

1 Ø Naturei

2 Accident

4 Homicida

3 ☐ Suicide

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es steted.

2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner eteted.

29b. Signetura and title of certifian

29c. Licansa number

23300

29d. Data signed (Month, Day, Year)

MARCH 03

1998

ND, 30. Meme end eddress of person who completed cause of deeth (item 23a) (Type, Print)

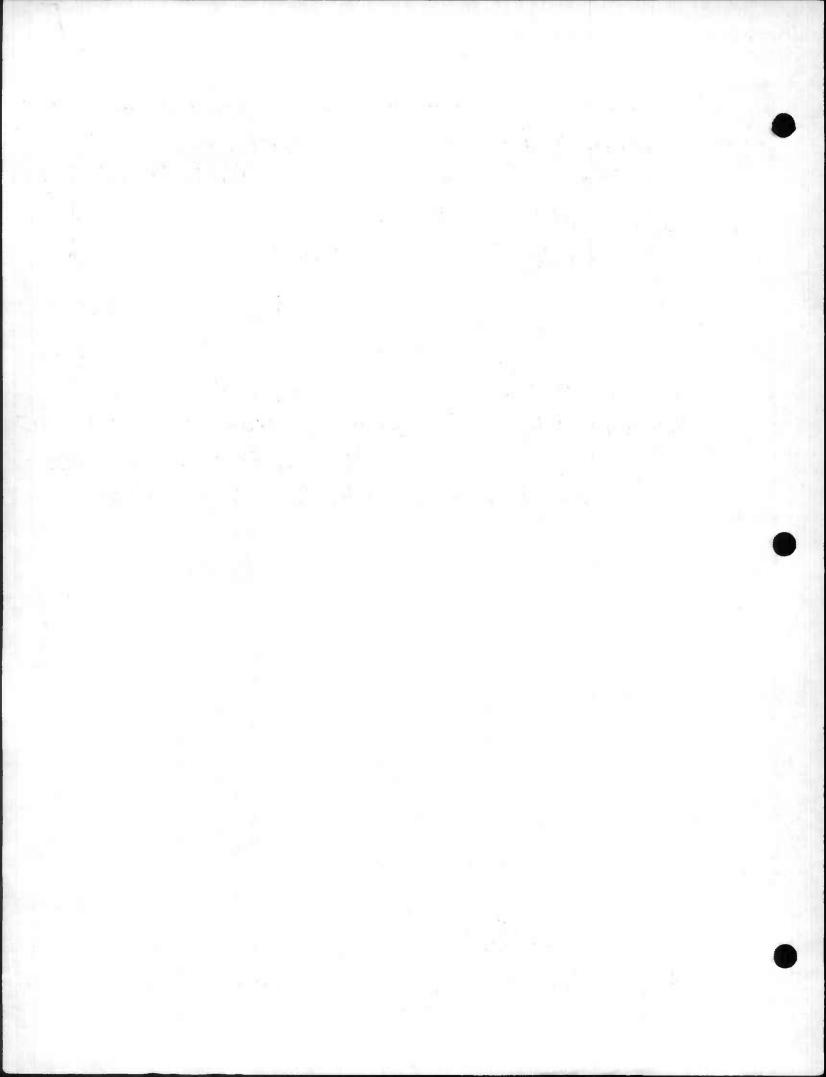
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State Registrar

31. Data filed (Month, Dey, Year) 1998 5

32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

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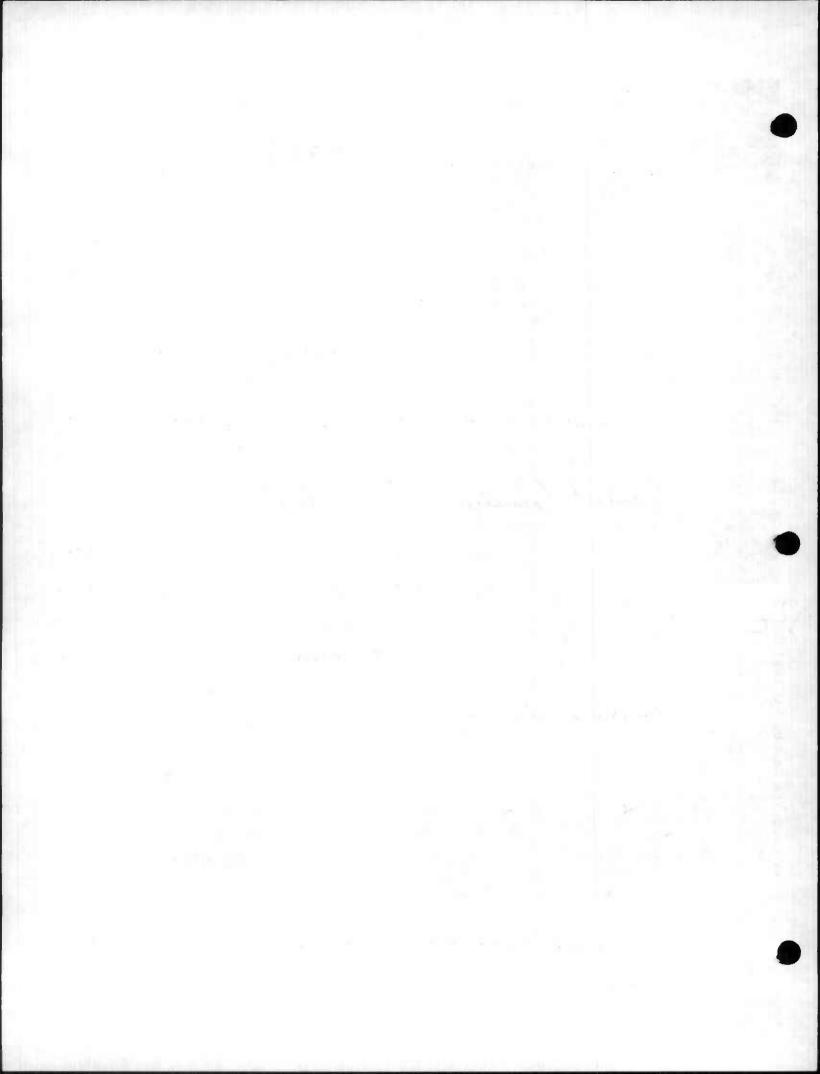
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1		John A. Speeder W.D. 97460 March 30. Nema and address of parson who completed cause of death (Itam 23a) (Type, Print)								2,1	998	
6		Jeffrey A Spaeder, 31. Data filed (Month, Day, Year)	H.D. JHB	HC 49		aston A	ve Balt	imore, H	d. 2122	4		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 3. Time of Death 2. Data of Death Day **Physician** MARGARET VIRGINIA FAHEY MARCH 4, 5:20 AM 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, giva street and number) Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (Stete or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2CKF Yrs. Director 220-42-7140 Sept. 5, 1912 Virginia Usual Residence of Decedent the Marylend 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits r 28a-f ehow 1 ☐ Yes 2 No Directo Md. Baltimore Lutherville 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours effer death with t Department of Haalth and Mentai Hygiena. I important: If Itam 27 is marked other than "naturel", or items 23a or 2 any injury or other traumstic event, the Medical Expenses or 2 above. 1414 Front Avenue 21093 U.S.A. Funeral 14. Race - Amarican Indian, 12. Was Decedant Ever in U,S. Armed Forces? Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Biack, White, atc. 1 Yes 2 No If Yas, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: à 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highast grada completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Admitting Officer Hospice Care 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumeme) Be Thomas V. Tumbleson Lila Hogan 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Lutherville, Maryland 21093 Ms. Marie T. Fahey/Daughter #8 Felton Road 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Dulaney Valley Mem. Grd. 3/7/98 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 22. Name end Address of Facility 21. Signature of Funeral Servica License Ruck Towson Funeral Home, Inc. Leves Towson, Maryland 21204 mplications that canded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ily one cause on each line. 1050 York Road 23a. Part1. Enter the disaase, or form shock, or heert feilure. List only Approximate Interval Batween Onset and Death **Physician** RESPIRATORY FAILURE /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Due to (or es e consequenca of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): physican the buriel Box 68760. Physician/Medical Due to (or es a consequance of) lew requires that the death certificate 65 usa signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? o 1 ☐ Yes 2 ☐ No 3 □ Probably 4 ℃ Unknown CORONARY ARTERY DISEASE Records, à 24b. Were eutopsy findings available prior to been si 24e. Wes en autopsy Completed **PNEUMONIA** complation of cause of deeth? certificete has t director, paga 2 s The 1 Yes 25 No 1 Yes 2 No Division of Vital or Attending Physicien: director, 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 2 1 ☐ Yes 2 No 1X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2 No investigation after death Director: A d in by tha fi death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directorn pletely filled in by 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piace, and due to the cause(s) end manner stated. 29a, Certifier edical (Check only one) 29b. Signature and title of certify 29c. License number 29d. Data signed (Month, Dey, Year) 37254 1 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

31. Data filed (Month, Dey, Year)

BOON P. LIM,

MAR 05 1998

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Carol Mullen Fox 1998 2355 HRS MAR 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore N/A If Undar 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Months Days 1 M 2 KF Yrs. 55 18, 1942 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 □ No Baltimore 10f. Zip Coda 10g. Citizen of What Country? 900 Cathedral Street #501 21201 United States 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Marriad 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) Elamantary/Secondary (0-12) College (1-4or 5+) Social Worker Head Start 4 18. Mother's Name (First, Middle, Majden Sumama) 17. Fathar's Nama (First, Middla, Last) Betty Kearney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Brendan Fox / Son 900 Cathedral St., #501, Baltimore, MD 21201 20b. Place of Disposition (Neme of cematery, cremetory or other pleca) 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 3/4/98 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Servica Licani 3620 Wilkens Avenue, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only see cause on each line. Approximata Interval Between Onset and Daath SEPSIS 17 DAYS Due to (or as a consaquanca of): 1RINARY TRACT INFECTION Due to (or as a consequanca of): DAYS PULMONARY EMBOLISM Dua to (or as a consequence of)

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altimore, Maryland 21215-0020

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Funeral

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Completed

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5. Social Security Number

266-64-0167

10e. Street and Number

John Mullen

20a. Method of Disposition

Immediate Cause (Final diseasa or condition resulting in death)

N/A

10a, State

Maryland

Physician/Medical Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last isvho

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

OVAFIAN caucer

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to madical examiner? 1 Yes 2 10 No

5 Pending

invastigation

27. Manner of Death

1 Accidant

3 Suicide

29a. Certifian

4 Homicide

(Check only

28a. Date of Injury (Month, Dey Year)

1 Conpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred

6 Could not be detarmined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. Licanse number

52544

26. Place of Daath (Check only one)

Mar 2, 1998

, physician 30. Nama and address of parson who completed causa of death (Itam 23a) (Typa, Print)

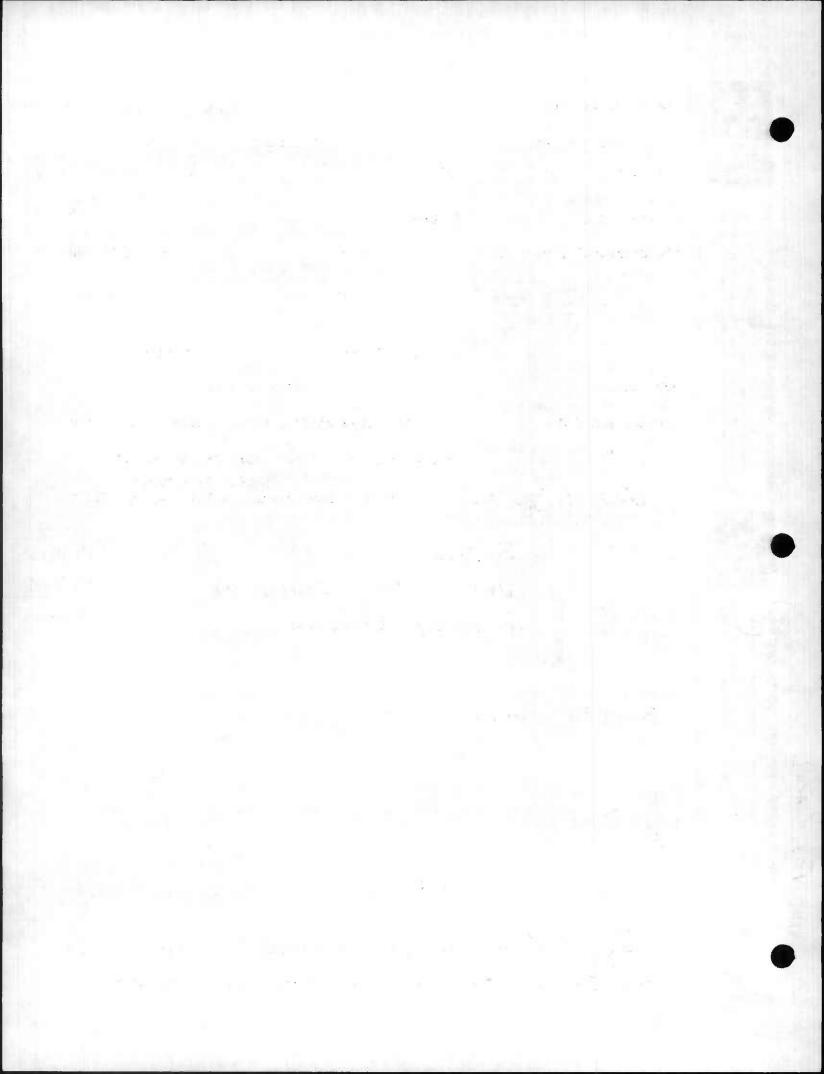
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900 cation Ave., Baltomore, m.D 21229 St. Agnes Hospital Benjamin S. Lee, M.D. 31. Date filed (Month, Day, Yaar)

State Registrar

MAR 05 1998

32. Registrar's Signature while widson-Randale



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of the **Physician** M. Naomi Fisher Feb 98 2:00 A.M. /Medicai 4a. Fecility Neme (If not institution, giva street and numbar) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Roland Park Place Baltimore if Under 24 Hrs. Hours Min. 5. Social Security Number If Undar 1 Yaar 7. Age (In yrs. lest birthday) Birthpieca (Stete or Foreign Country) 8. Data of Birth (Month, Dey, Year) Months Devs 10 M 20 F Yrs 064-14-8577 90 1/13/1908 P.A. Usual Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 830 W. 40th Street Roland Park Place Apt 105 Funeral 21211 U.S.A. Was Dacedant Ever in U,S. Armed Forcas? Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married 1□ Yas 2 No Specify: þ Specify 3 Widowed 4 □ Divorced Year or Detes: White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decadent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be John M. Evans 5 Mary V. Norris 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jacqueline Wolfe / Daughter 4411 Greenway Baltimore, MD 21218 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Paltimore Washington Crematory 2-27-98 21. Signeture of Funeral Service License 22. Nama and Address of Fecility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc. 2134 Willow Spring Road Baltimore, MD 21222 23a. Part1. Enter the diseese, or complications that caused the shock, or heert failure. List only one ceuse on eech line. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Intervei Between Onsat and Death Immediate Ceuse (Final diseese or condition resulting in deeth) Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consaguenca of): Due to (or es e consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a, Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending Investigation 1 Yas 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

ettending physician and for use as the buriel-trensit P.O. Box 68780 that the death certificate be 88 ed by the e signed t Records, The law requires pege 2 should b certificata has Division of Vital Physician: director. this funeral After or Attanding death. 24 hours after deat Funeral Director: filled in by Hospital complataly

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic evant, its Mudical Examinar must be notified all

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health end Mantal Hygiena. Important: if Itam 27 is merked other than "natural", or iten any injury or other traumatic event, it a Madical Exempt

Physician /Medicai

Examiner

Baltimore, Maryland 21215-0020

the Maryland

Physician/Medical Examiner Completed by Be Certification: To

4 HomicIde 29e. Certifier Medical (Check only one)

Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted.

| Medical Examiner: On the bests of exeminetion end/or invastigetion, in my opinion, deeth occurred ef the time, date end place, end dua to the ceuse(s) end manner steted. 29b. Signatura and fitta of cartifier

29c. License number

29d. Data signed (Month, Day, Year) 98

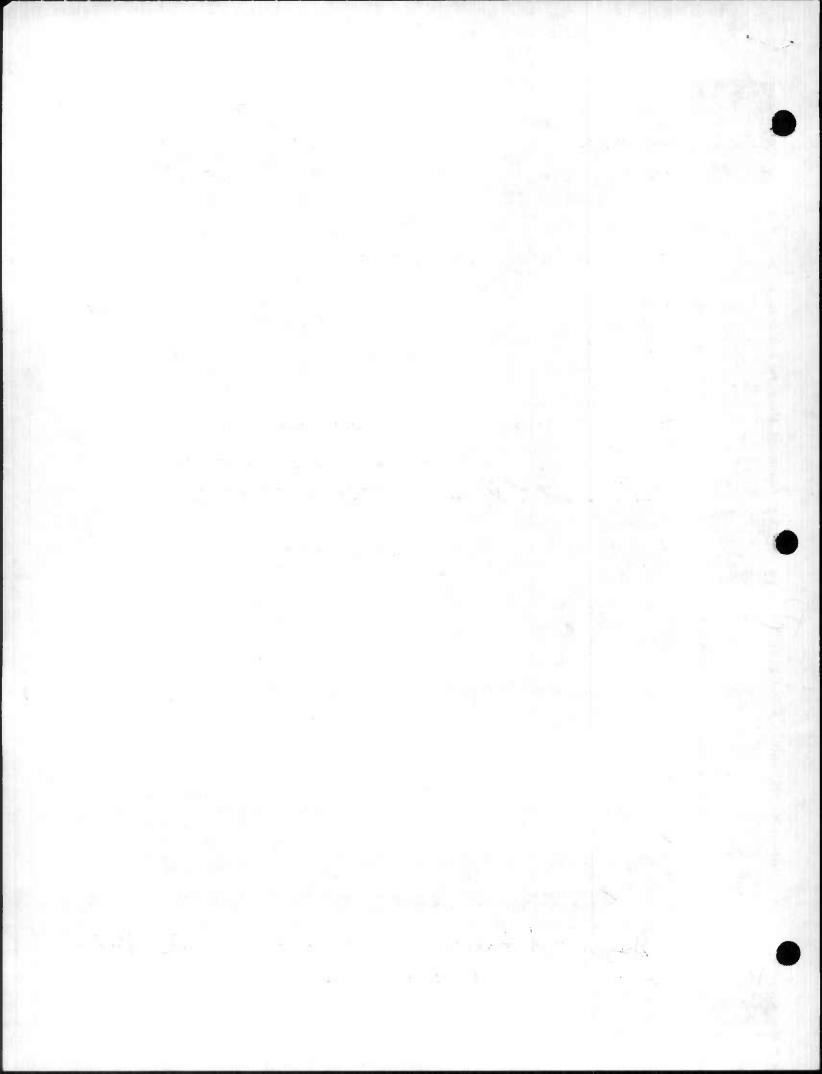
30. Name and eddress of perion who completed cause of deeth (Item 23e) (Type, Print) 333 al VERT N. Suite 540 ; 21218

31. Dete filed (Month, Day, Yeer)

32 Pagistrar's Signature Pandall

State Registrar

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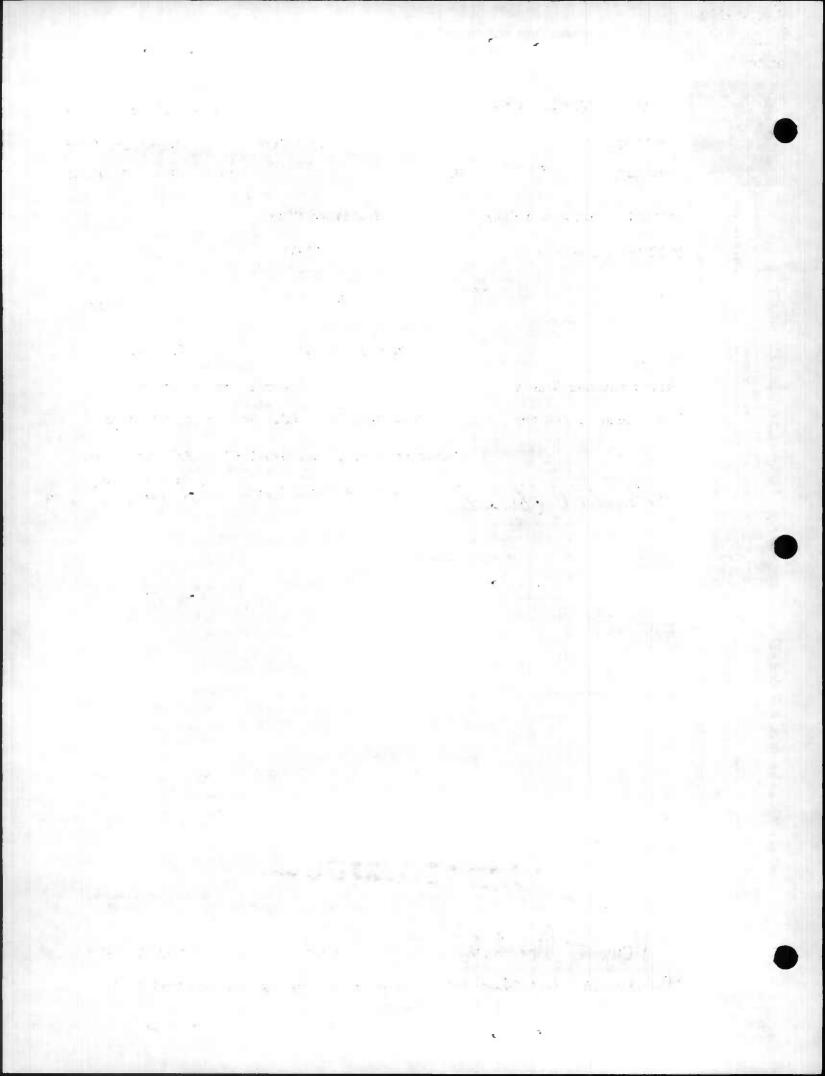
State Registrar HERYATURA

31. Date filed (Month, Dey, Year)

MAR 05 1998

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Republication Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06935 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Daath Day Month Year M:15 A.M. **Physician** 71/1am ton ebruary 28, 1998 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 33 embridge caltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 219-28-1442 10 M 20 F 65 Yrs. . C Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Moorest Examiner must be notified at 1 Yes 2 □ No NA Baltimore Director MO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 5133 15.A RMbridge Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 D(Yes 2 □ No If/Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 DXNo Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Bethlehem Elamentary/Secondary (0-12) College (1-4or 5+) Steel Laborer ch) grade NA 17. Fether's Name (First, Middle, Last) 18 Mother's Nama (First, Middla, Maidan Surname) Norman Moses Gilliam 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number of Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is,
any injury or other trau Balto,)eborah Md 21215 1) aughter 20c. Location - City or Town, Stete 20a. Method of Disposition 20b. Plece of Disposition (Name of Date emetery, crematory or other place) Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) eteran 21. Signature of Funeral Service Licansae 22. Name and Address of Facility 00 grenue Wabas 23a. Part1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one causa on aach lina. Approximete Interval Batween Onset end Deeth **Physician** Immediata Causa (Final EAT disease or condition rasulting in daath) Examiner Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 200 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 DNo Be 25. Was case rafarred to medical axaminar? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 ☐ Could not be datarminad 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida

/Medical Examiner Division of Vital Records, P.O. Box 68760, physiolan certificate that the attending 3 the signed by peed law. has page 2 The certificate Physician # furnaral After Attending after death Director: 8 e Funeral F Hospital å

death with the Maryland

filed within 72 hours after

I Hygiene.

Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If item 27 is marked other t

Baltimore, Maryland 21215-0020

Within 2 To the B

State Registrar

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29a. Cartifiar

(Check only one)

filed (Month, Day, Year) MAR 05

29b. Signature and title of certifier

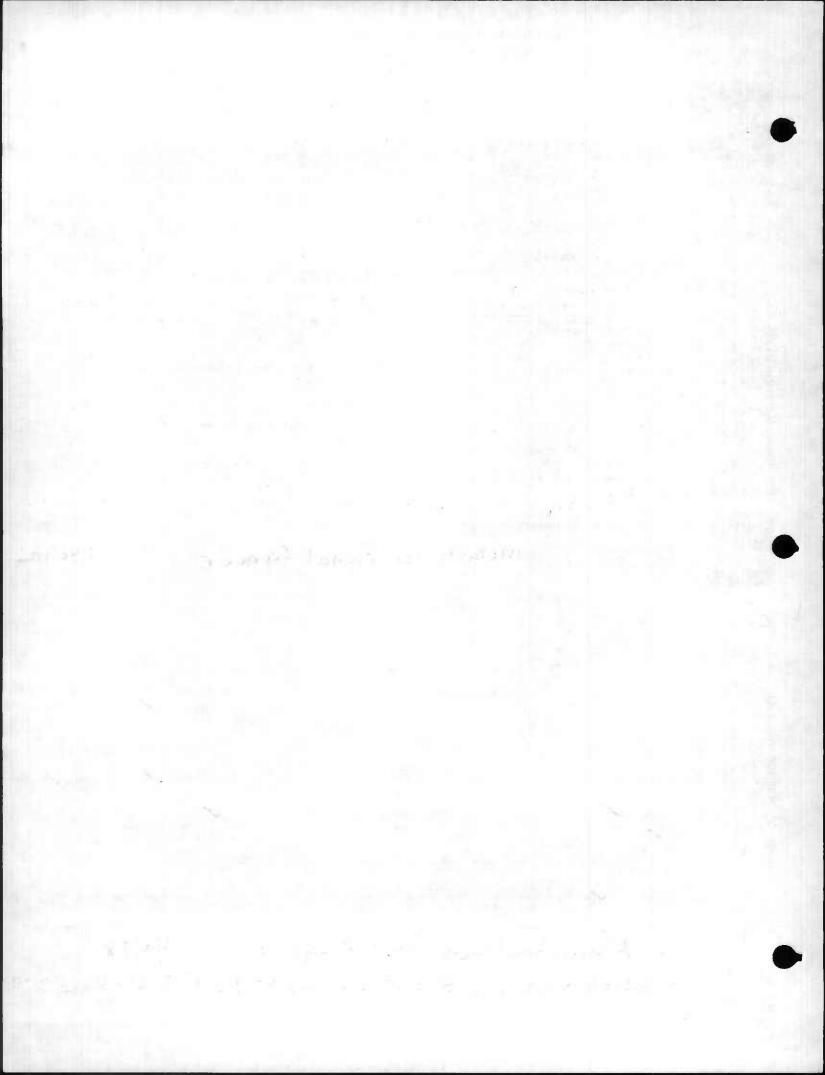
Julia Varison-Randade

29c. License number

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 57#305 BA 32. Registrar's Signature

1 Certifying Phyalcian: To the best of my knowledge, death occurred at tha tima, dala and place, and due to the ceuse(s) end manner as stated.



98-1174-027 UNK.#98-049 YZ a

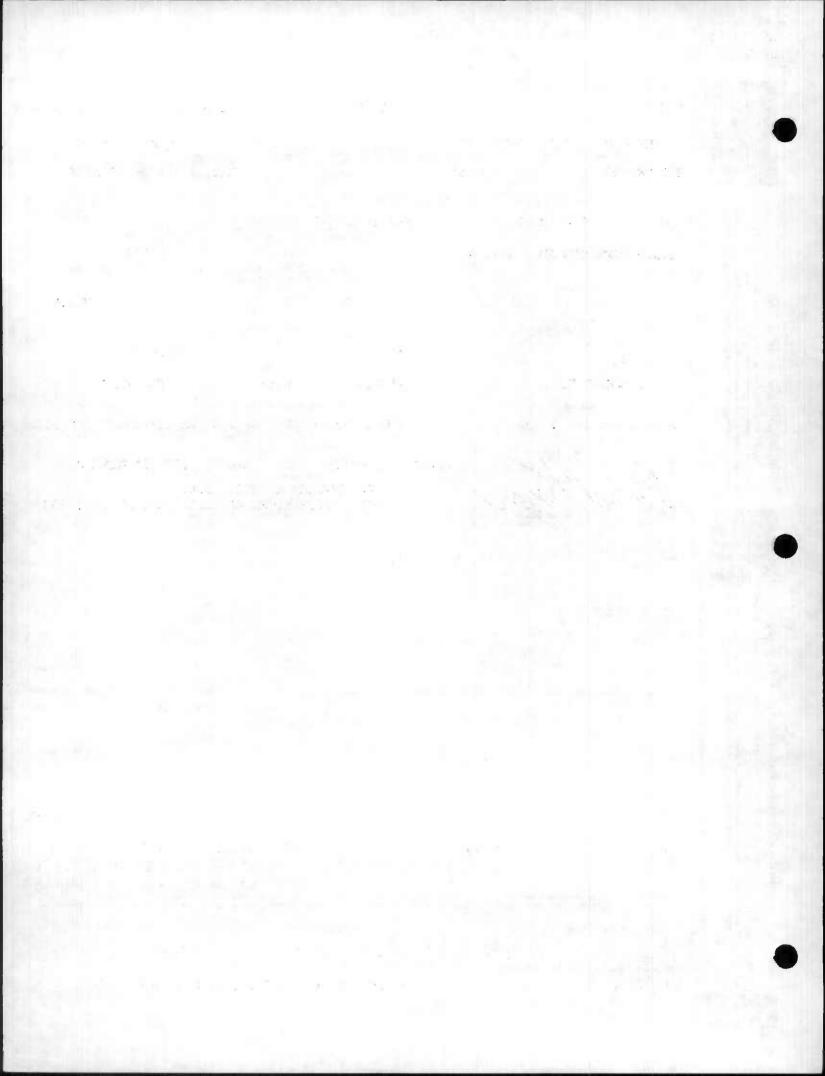
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	1	30. Neme end eddress of person who c	ompleted cause of death	(Item 23a) (Tv	pe, Print)	O.C.M.E.		MAKCH	03, 1998	-	
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Registrar

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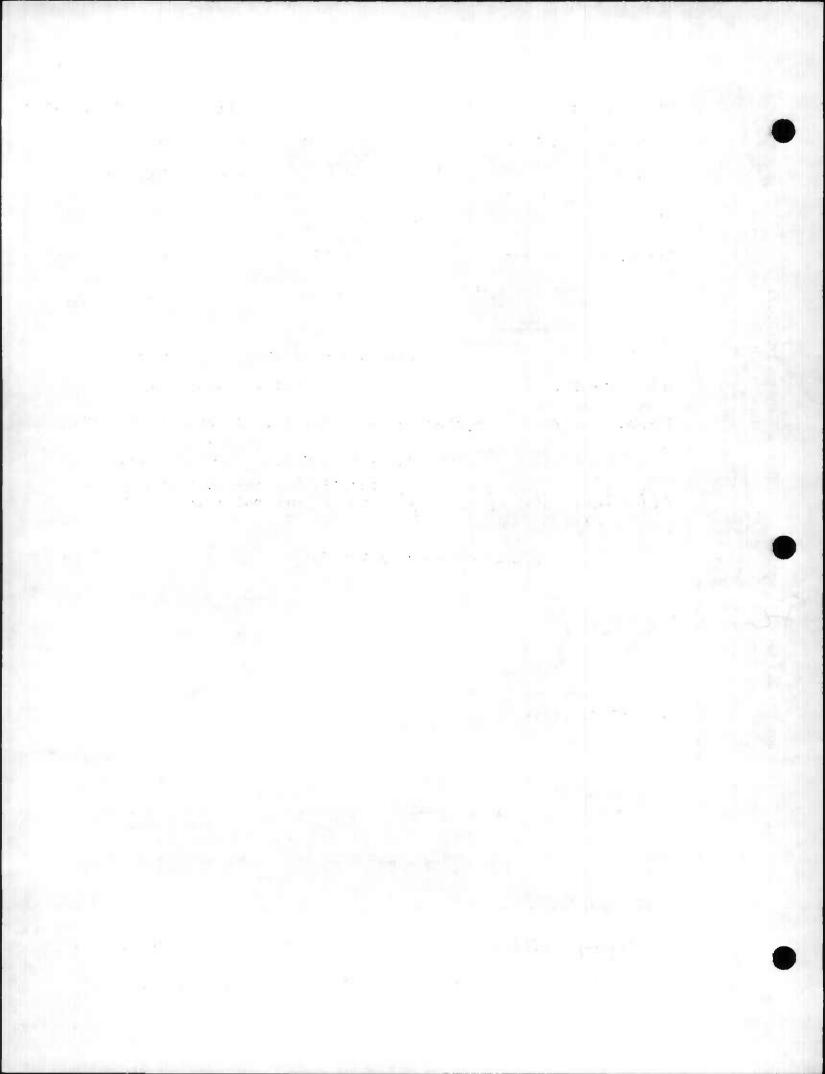
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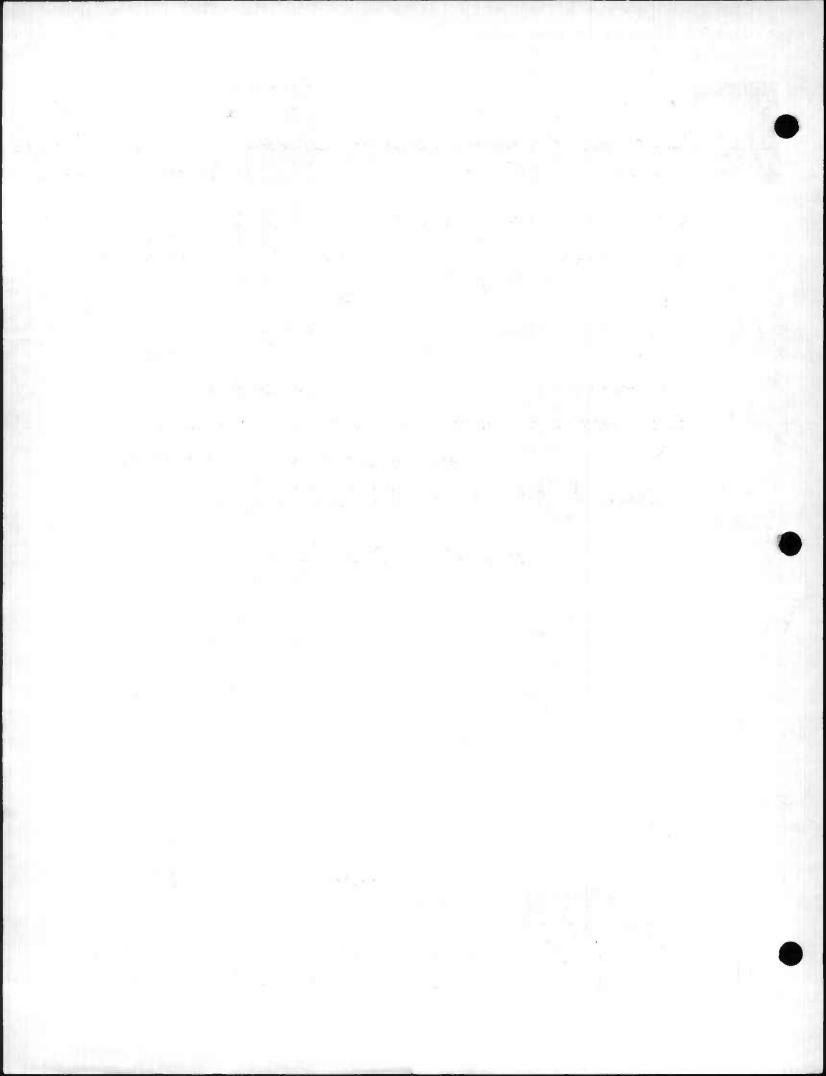
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3 5	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co									What Cou	ntry?			
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r tr	5	Sharon Humph	rey	/da	ughte	r 60	616	Bush	ey S	t. 1	Baltir	nore, l	MD 2	1224
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	238	23a. Part1. Entar tha disease or complications that ceused tha death. Do not enter the mode of dying, su shock, or heart failure. List only one ceuse on each line.								cardiac or	raspiratory er	est,		Iniarval Batween Onset and Death
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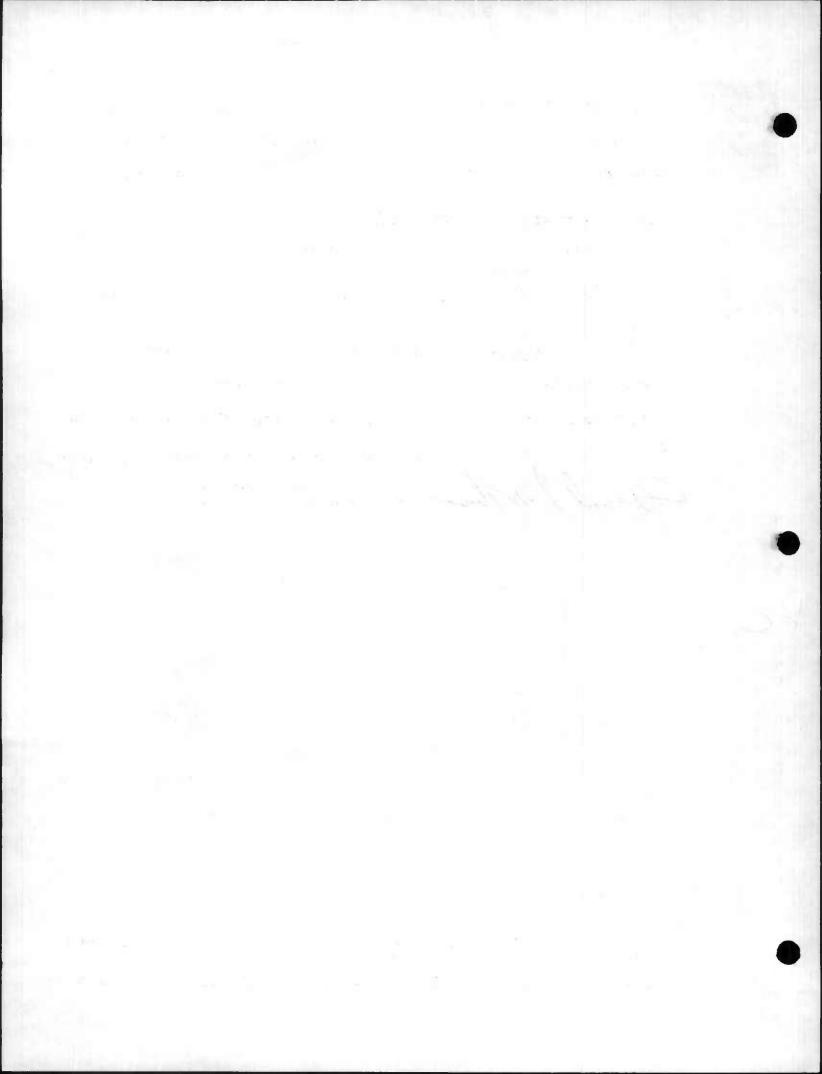


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show		10a. State 10b. County	10c. City,	Town or Loca	ation				100	d. Inside City Limits	
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De na	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Countr	у?	
INUST INUST	Funeral	3302 SWANN ROAD 11. Marital Status 12. Was De	cedent Ever in U,S.	13 W	2074		(Specify Ves or No	UNITED	STATE ce - America		
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the Medical Exp	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondery (0-12) College	life. DC) NOT use retire	pation during most of w d)	vorking	16b. Kind of B	Business/Indu	ustry		
		17. Father's Name (First, Middle, Last)		DOMES	TIC	18. Mother's N	eme (First, Middle	PRIVAT		1	
	To Be										
tract		MARY L. WHITE KYLES, DA					SUITLAND,			746	
_		20a. Method of Disposition	20b. Plac	ce of Disposit	tion (Name of tory or other pla		Date	20c. Location			
Injury or		1 ABurial 2 ☐ Cremetlon 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State		OLN CEM		2/28/98	BRENTWO	OOD, M	ARYLAND	
any injury		Signeture of Funeral Service License Sa. Part1. Enter the disease, or comblications that shock, or heart failure. List only one ceuse on	caused the death.) FO 34	01 BLADI	OLN FUNE	RAL HOME RD., BRE	NTWOOD.		722 Approximate nterval Between	
sician edical miner miner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Einer Underlying	,	as a conseque		u.a				Onset and Death	
s the bur	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
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e funeral dire		27. Manne of Death 1 Natural 5 Pending (Mo 2 Accident Investigation	Home 5 Resident Resid	how Injury occur							
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plataly fill	dicar	29a. Certifier (Check only one) 1 Certifying Physician: To th 2 Medical Examiner: On the i	e best of my knowle basis of examination oner stated.	edge, death on end/or inves	ccurred et the tir stigation, In my o	ne, dete end ple pinlon, death oc	ca, and due to the curred at the time,	cause(s) and modate end place,	enner as stat and due to th	ted. he cause(s)	
completely filled	e II.	29b. Signatuse and title of certifier			29c. Licens	e number		29d. Date signe	ed (Month, De	ay, Year)	
		30. Name and eddress of person who completed cau	-Carl	John 30) (Type Pri	D4	5881	/	2/2	2/91	7	
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State Registrar		31. Date filed (Month, Day, Year) 32.1 MAR 0.5.1998	en strar's Signature		00_						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First Middle Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Joseph Francis Getka 9:00AM February 26, 1998 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 42 Melvin Avenue Catonsville Baltimore 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Manth, Dev. Yeer) 12/4/1923 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Deys Hours 1**X** M 2□ F Yrs. Director 217-20-3098 Maryland Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show Director Maryland 1 Yes 2 □ No Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? filed within 72 hours efter death with 42 Melvin Avenue 21228 USA Completed by Funeral нетв ; 12. Wes Decadent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indlen, Bleck, White, etc. "natural", or items 1 Never Merried 3 Married 1¥0¥es 2□No If Yes, Give Yeer or Dates: WW II 21215-0020 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 end 2 should be filed within nent of Health end Mental Hygiene. ant: If Item 27 is marked other than ury or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event, the Merican or other traumatic event. Pharmacist Healthcare years Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Francis Gietka Lasek Anna 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) June K. Getka / Wife 42 Melvin Avenue Catonsville, Maryland 21228 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete **Buriel 2 Cremetion 3 Removel from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 3/2/98 Baltimore, Maryland of Funeral Service Ocean 22. Name end Address of Facility David J. Weber Funeral Home 23e. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 5311 Edmondson Ave. Baltimore, Maryland 21229 Approximete Intervel Between **Physician** /Medical Immediate Ceuse (Finel au diseese or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Box 68760 Physician/Medical phys Due to (or es e consequenca of) The law requires that the death certificate 88 980 ate hes been signed by the e page 2 should be detached for P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings evelleble prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 ☐ Yes 2 No this certificate Division of Vital or Attending Physician: director, Be 25. Wes case referred to medical 28. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidenca 6 Other (Specify) Certification: To 1 Yes 2 No funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident efter deeth Director: 8 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 24 hours e Hospital 1 Cartifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner steted. 29e. Certifier Medicai completely (Check only one) To the Vithin 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) llul 30. Name end eddless of person who completed cause of death (Item 23e) (Type, Print) STEPHEN PLANTHOUT AVE, BALTO, MD 21229 MD WILKENS Pegistrar's Signeture The Daydson-Randell 31. Date filed (Month, Dey, Year) State MAR 05 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37 3/5/98 reb Certificate of Death Reg. No. Item:5 per F.H. G-757 Item: 1 per M.D G-757 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month GROSS aka 26 LIDNEL CARL 1923 Junior Jennings FEBUARY /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deal **Examiner** HOSPITAL BALTIMORE 26 SINAI 1101 If Under 1 Year If Under 24 Hrs 5. Social Security Number last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1XM 2□ F **Director** 214-24-9059 ano Usual Rasidenca of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Pagas 1 and 2 should be filed within 72 hours after death with tha Marylar mant of Haaith and Mental Hygiena.

Int: If Item 27 is marked other than "naturel", or items 23a or 28s-f show ury or other traumatic event, the Medical Examiner mant to notified at Maryland Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Inwa by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yas 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 14. Race -American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0020 1□ Yes 2E No specity: 3 Widowed 4 □ Divorced American Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com, 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nan seaman Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Informant's Name/Relationship (Typen Print) / (aughter, 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Department of Health er important: If item 27 is any injury or other trsu once. 12 . Method of Disposition

1 △ Burial 2 □ Cramation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Factility

JOSEPH L. NO. era 2222 North Ave 20 transport of complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, that only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final yre PROSTATE CANCERS disaasa or condition resulting in death) **Examiner** Tha law requires that the death cartificete be executed bunal-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last and MERKACEMIA P.O. Box 68760, physician Physician/Medical Due to (or as a consaquence of) usa as tha signed by the at id be datached for Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown Records, by Be Completed 24a. Was an autopsy performed? 24b. Were eutopsy findings availabla prior to completion of cause of death? page 2 should peeu this cartificata hes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA the funaral 27. Menner of Death 1 Natural 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? Aftar 5 Pending investigation Injury s after daath. 1 Tes 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) filled in by 4 Homicide ò To the Hospital of within 24 hours all To the Funeral D complataly filled Medicai 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and placa, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of contilies 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person WOO. MD amuel 31. Date filed (Month, Day, Year)

MAR 05

who completed cause of death (item 23e) (Type, Print) Sinai Hospital

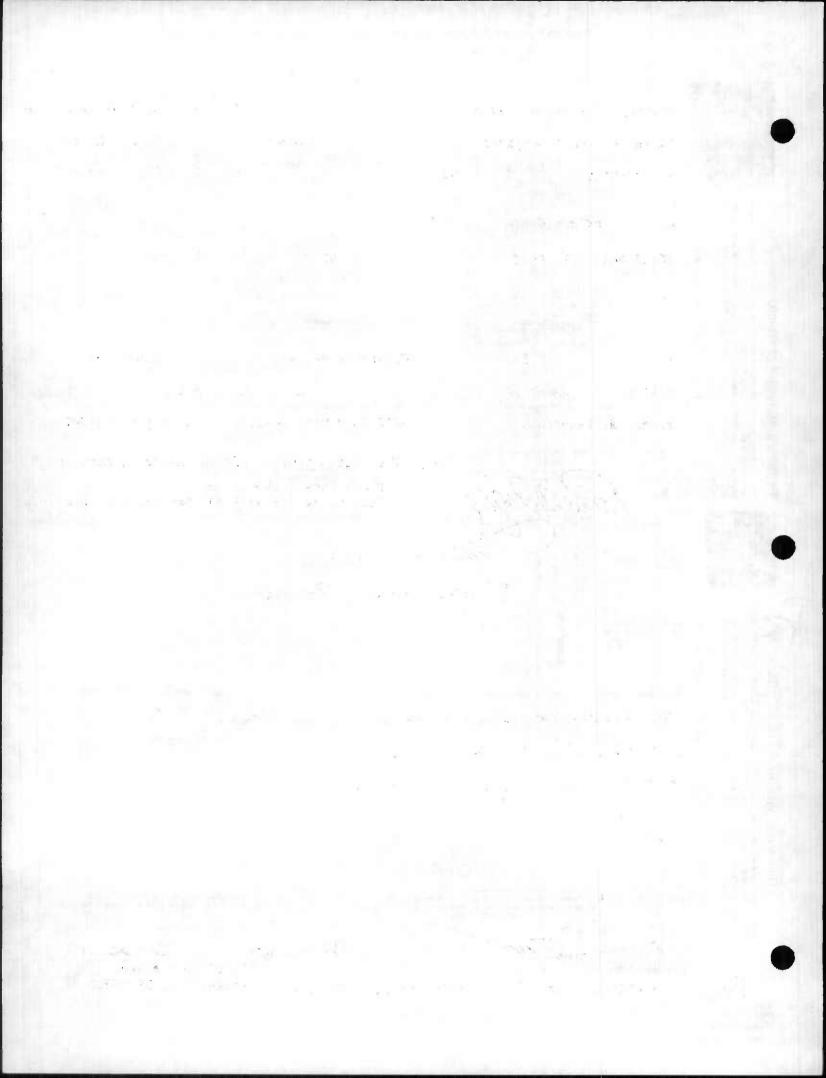
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2401 W. Belvodere Ave Balt

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene.

			State o	Maryiai		tificate of	neaith and i Death		Reg. No.	06	941
	1. Decedent's Nen	ne (First, Middle, I	ast)		0 7			2. Data of De Month	ath Day	Yaer	3. Time of Deeth
Physician /Medical	Dorothy	Elizab	eth Han	na				Februa			7:00 a.m.
Examiner	4a Facility Neme	(If not institution, g	iva streat and nun	nber)			4b. City, Town, or I	Location of Death	4c. County	of Deeth	
No. of the last		Regional	-			611 · 314	Laurel			nce Ge	
Funeral Director	5. Social Sacurity Number 218–20–0115		Sex 1□ M 2X F	7. Aga (In yrs. 93	lest birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	(Month, De	y, Year)	9. Birthple Countr Mary	ece (State or Foreign y) yland
death with the Maryland ms 28s or 28s-f show count be notified at near all Director	10a. Stete	Usuel Residence of Decedent							9	10	d. Inside City Limits
the Maryla r 28s-f show notfled st	MD	Prince	George	Lá	aurel						
or 2	10e. Street and Nu	ımber				10f. Zip Code			10g. Citizen of V	Whet Countr	y?
ath w		ond Mill				20707			USA		- bdi
_ i # 5		ried 2□ Married	Armed Fo	2 No		Vas Decedent of H Yas, specify Cubo	lispenic Origin? (S en, Maxican, Puert Specify:	pecify Yas or No o Rican, etc.)	Specify	e - Amarica ck, White, a :: Wh:	
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be filed that dother event, I Be Cc	17. Fethar's Neme	(First, Middle, La	st)				18. Mother's Ner	ne (First, Middle,	Maiden Sumen	ne)	
Maryland 2: do 2 should be filed w the and Mental Hygies T is marked other it traumatic event, in To Be Coi	William		rshall				Annie		arr		
6 0 0 T E	19e. Informent's N						end Number or Ru				
		M. Hanna	/Son	206			ill Road	, Laurel	20c. Location		
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Baltimo permit. Page Department of Important: If any lojury or once.	22. Name and Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 2070 23a. Part 1. Eriter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, Interval Bereth Chest and C										
Physician /Medical · Examiner	Immediata Causa disaesa or conditi	(Finel	molications that of	and line		er the mode of dyir	ng, such as cardiad	or respiratory e	rrest,		Approximete Intervel Between Onset end Death
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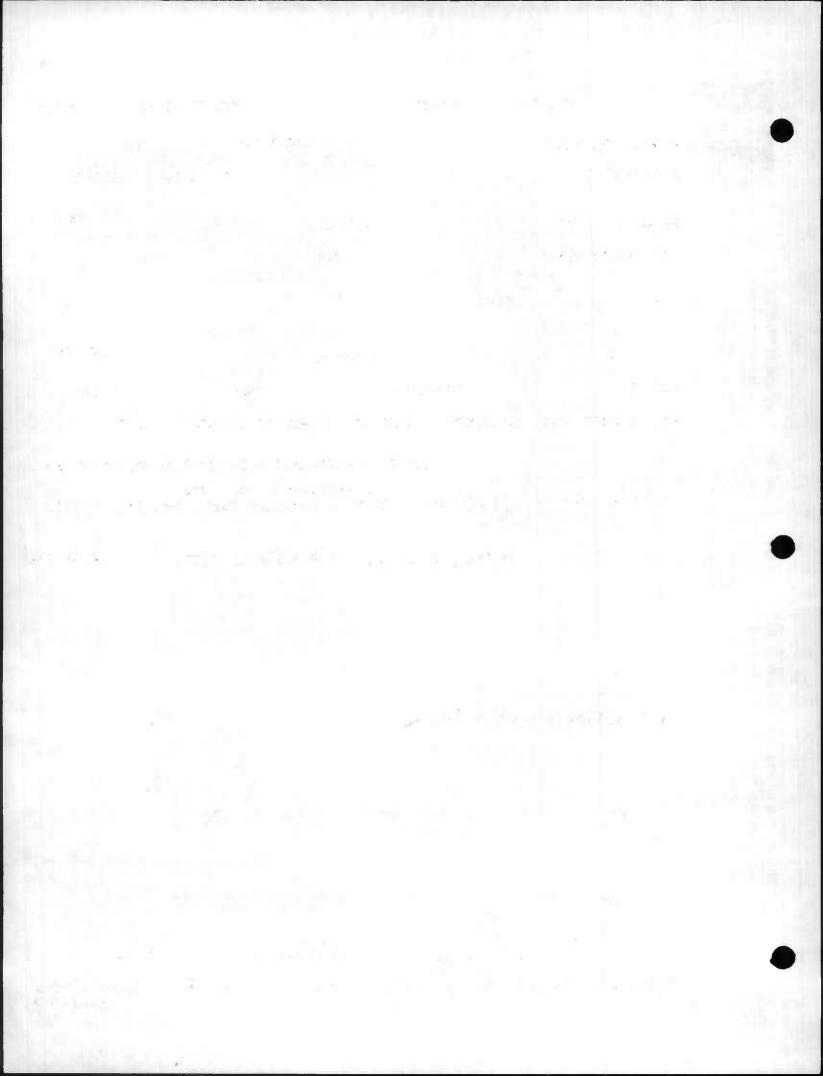


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1998 MILDRED HARRIS FEB. 28, 5:15pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 6906 DORSET PLACE If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Data of Birth (Month, Day, Year) Birthplacs (State or Forsign Country) Sex 1 M 2 F **Funeral** Days Yrs 214-30-2642 79 **Director** FEB. 8,1919 MARYLAND Usuai Rasidence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or flems 23a or 28a-f ahow traumstic event, the Medical Examiner must be notified at 1 Nes 2 No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6906 DORSET PLACE 21215 Funeral USA 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Race - American Indian, Black, White, atc. 11 Marital Status 1 ☐ Yes 2 XNo If Yas, Giva Yaar or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: à 3 ♥ Widowed 4 Divorced WHITE Completed 16a. Dacedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) OWN HOME 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surname) MORRIS SNYDERMAN ANNA HURWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. HARRIET BARON (DAUGHTER) 8506 WINANDS ROAD BALTIMORE, MD 21208 20b. Placa of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BETH EL MEMORIAL PARK - 3-2-1998 RANDALLSTOWN, MD 21. Signatura of Funaral Service Licensee 22. Name and Address of Facility Sol Levinson & Bros., Inc. armos 8900 Reisterstown Road Pikesville, MD 21208 23a. Part1. Enter the disease, or complications to caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician /Medical Immediate Causa (Final disease or condition rasulting in death) MELANOMA **Examiner** Due to (or as a consaquanca of) Examiner Sequentially list conditions, if any, leading to Immediate causa. Entar Underlying Cause (Disease or Injury that Initiated avents resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): the 80 nse Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 □ Yes à Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home Residence 6 Other (Specify) 2 1 Yes 2000 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Vatural 5 Pending investigation 1 ☐ Yes 2 ☐ No r death. 2 ☐ Accident birector: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At homa, farm, streat, factory, office bullding, etc. (Specify) filled in by 4 Homicide To the Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical completaly (Check only within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signature and title of ceruller 29c. License number 035600 W 30. Name and address of person who og cause of death (Item 23a) (Type, Print) CHOCKDAS OR #44 OUGHOS MELLY Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death MANSER ATHERINE ELIDABETH LIARCH 1998 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) If Under 24 Hrs. KOAD HARFORD DOOWZLOAZ APT If Under 1 Year 9. Birthplece (Stete or Foreign Country) 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 1□M 2⊠F Months Deys Hours Min. Yrs. 212 36 0965 Usual Residence of Decedent FIPRIL5, 1920 1 10e, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLEGO HARFORD 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 1801 6 AMPBU 21050 S.A CAD 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11 Marital Stetus Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed ANDivorced ZITHW 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede com completed) Elementary/Secondery (0-12) College (1-4or 5+) PLERK SOCIAL SICURIT 12 YRS-18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) 1 ARY B. ELLi CHARLES 21014 19a. Intormant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ROAD MARYLAND BILAIR CHARLLI SIMANIZ 1213 ST. FRACE 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City of Town, State 20e. Method of Disposition MARCHO BALLIONER 4 □ Donetion 5 □ Other (Specify) MOUNT REMAIORY! 1998 21. Signature of Funeral Service Cicenson 22. Name end Address of Fecility P.A. BAL RIR C. HAPEL EVANS FURRAL WARATHO FORST ORIVI 23e. Pert 1. Enter the disease, or complications that course the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in death) Adenocarcinoma Main Stam Due to (or as e consequence ot): 3 months WITh Brain Metastasis Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last Due to (or as e consequence ot): Due to (or as a consequence ot): 23b. Did tobacco usa contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 210 No 1 Yes 3 Probably 4 Unknown Coronary artery disease 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yes 250 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? HOME OF HER 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) DAUGHIZR 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. tnjury et Work? 5 Pending investigation 1 Natural 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760that the death certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director,

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/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Haalth and Mentel Hygiena. Important: If Itam 27 is marked other than "natural", or Itama 23a or 28a-f show any highry or other traumetic avant, the Medical Examiner must be inclifted at once.

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29a, Certifier

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Baltimore,

State Registrar

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, end due to the ceuse(s) end menner as stated.

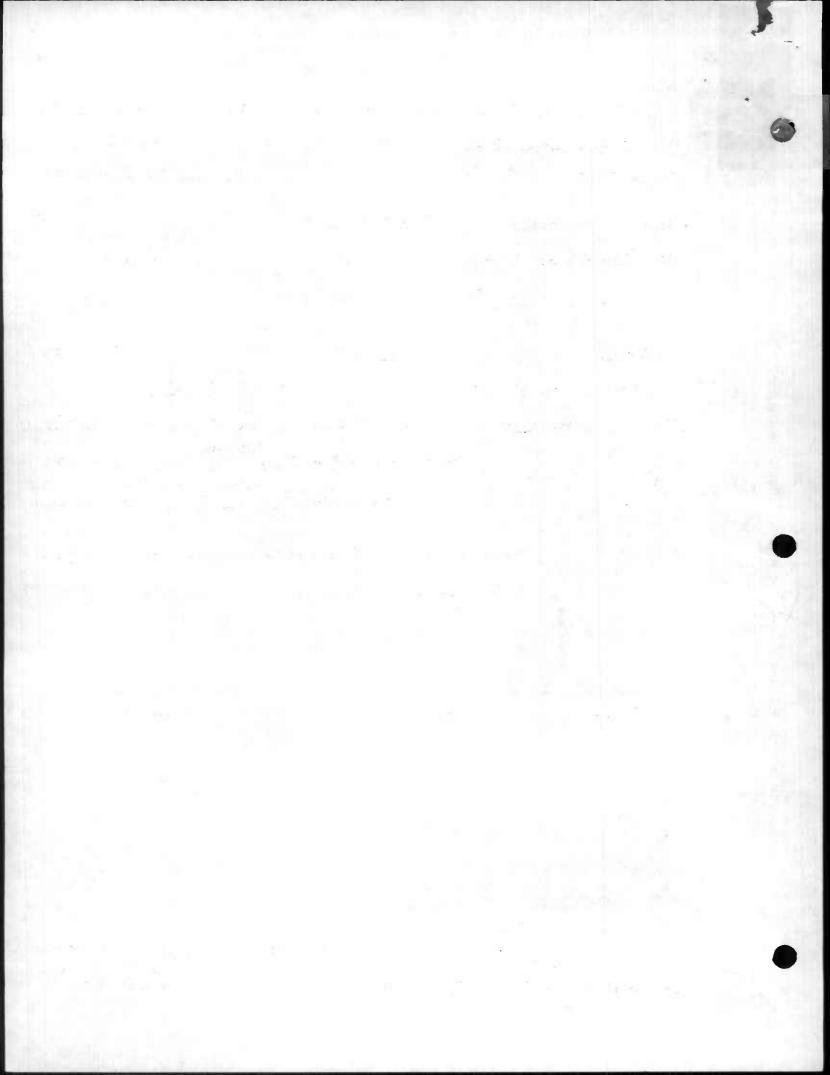
| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) and manner stated.

29d. Date signed (Month, Dey, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

R.B.D ARS HARFORD 1008

Fegistrar's Signature e Davidson



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death **Physician** Constance H. Harrison February 28, 1998 1:22 AM /Medical 4e Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** 926 Saint Agnes Lane N/A Baltimore If Undar 1 Yaar | If Under 24 Hrs. Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Days 1 M 2 F Yrs 75 219-10-0633 04/28/1922 Maryland Usuel Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore N/A 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number 926 Saint Agnes Lane 21207 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispenic Origin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, etc. 1 Never Married 2 Married 1 ☐ Yas 2 No If Yas, Giva X Yeer or Delas: Specify: White 1 ☐ Yas 2 ☑ No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completad) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Homemaker Domestic 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Surname) Constance G. Earl Prevost Harryman 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rurel Routa Numbar, City or Town, Stata, Zip Coda) Maria C. Singer/Daughter 928 Saint Agnes Lane Baltimore, Maryland 21207 20b. Place of Disposition (Nema of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) 3/3/98 Lakeview Cemetery Sykesville, Maryland 22. Nama and Addrass of Facility 23a. Part. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast,

Approximate shock, or heart failure. The mode of dying, such as cardiac or respiratory arrast,

Approximate shock, or heart failure. David J. Weber Funeral Home Approximete Intarval Batwaan Onset end Death Immediate Cause (Final disaasa or condition rasulting in death) Physician/Medical Examiner ardiac ames Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Ceuse (Diseese or injury lhat initieted avents rasulting In daath) Last Dua to (or as a consequence of) Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Intershal fistilae þ 24b. Wara autopsy findings eveilabla prior to complation of cause of daeth? 24a. Wes en eutopsy performad? Completed Gastrojh destinal 1□ Yas 2 No 1 Yas 2 10 No Be 25. Wes case referred to medical examiner? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2DNo 10 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 27. Mannar of Death 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Yaar) 28b. Time of 28c. Injury at Work? Certification: 5 Panding Invastigation 1 Yes 2 No 2 ☐ Accident 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Straet end Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straal, factory, office building, atc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowladge, death occurred at tha tima, data and place, and dua to the causa(s) and mannar es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar statad. 29a. Cartifier (Check only one)

Examiner ettending physician end for use as the burial-transit Division of Vital Records, P.O. Box 68760 signed by the e has this After t or Attending Director: in 24 hour. the Funeral Directory filled in by within 24 hor To the Fune completaly fi

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r than "natural", or items 23s or 28s-f show

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exeminations.

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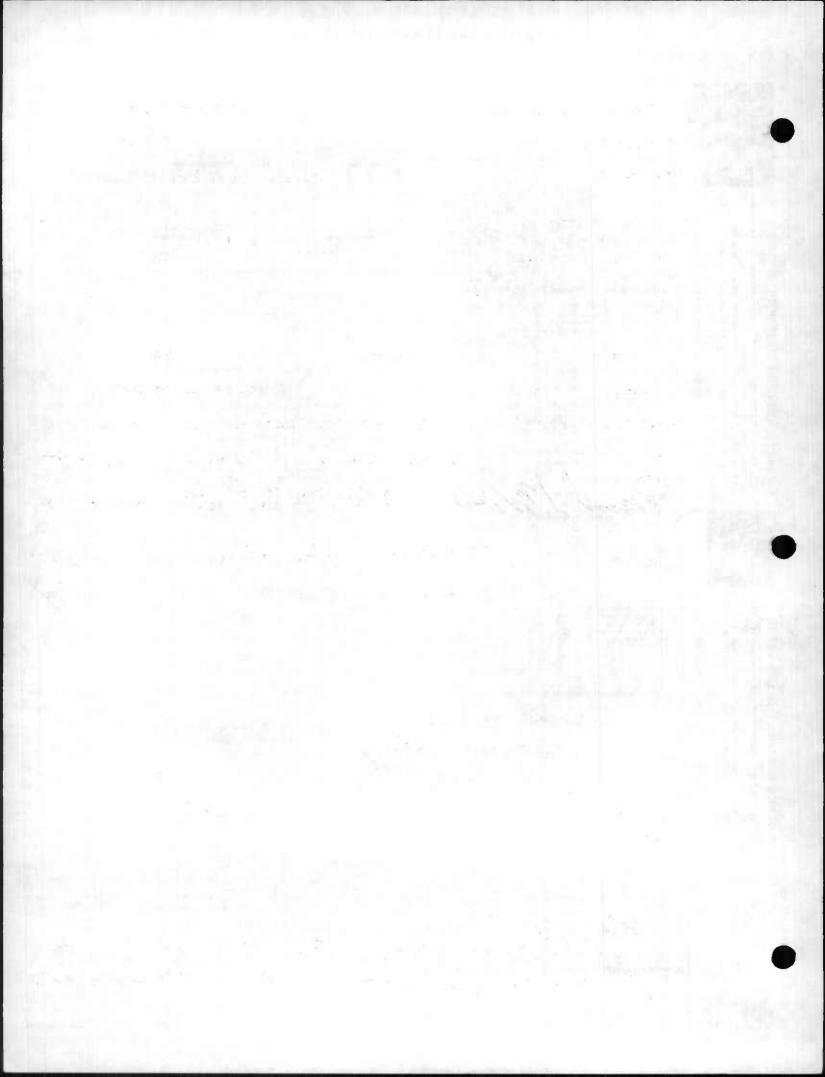
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth 3. Tima of Death **Physician** Month Richard Clifton

4a. Facility Nama (If not institution, give street and number) Je H 28 2 300 PM /Medical 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** BALTIMORE
If Undar 24 Hrs. 8. [DEATON MEDICAL CENTER If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** ₩ 2 D F Months Days Hours Min. Yrs. Director 219-38-5716 Usual Rasidance of Decedan 58 1/8/40 WEST VA 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show must be notified at 1 Yas 2 No Director MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ items 23a Funeral 2325 REISTERSTOWN ROAD 21217 U.S. 12. Was Dacedant Evar In U,S. Armad Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. permit. Pages 1 end 2 should be filed within 72 hours effer of Dependment of Heelth end Mental Hygiene. Important: If Nem 27 Is marked other than "natural", or iter any injury or other traumatic event, the Med call Examines 9068. 1 Naver Merried XXMarried 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2√2 No Specify: by 3 Widowad 4 Divorced BLACK Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 9 LABOR -0-LABORER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumema) RANDOLPH JETT CLARA FOX 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code) (WIFE) 2325 REISTERSTOWN ROAD-BALTIMORE, MD 21217 AGNES JETT 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) ZION CEMETERY 3/5/98 LANSDOWNE, MD 22. Nama and Addrass of Facility ELIZABETH L. PHILLIPS 21. Signature of Funaral Sarvice Licensee 1721-27 N. MONROE ST.-BALTIMORE, MD 21217 23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not anter the moda of dying, such as cerdiac or raspiratory arrest, shock, or heert failura. List only ona causa on eech line. Onsat and Death **Physician** /Medicai Immadiata Ceuse (Final Metartahe Cancer Lung 3 months disaasa or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner physician and the bunel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): P.O. signed by the e Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ð 24b. Wara autopsy findings avellabla prior to complation of ceusa of daath? 24e. Wes en eutopsy performad? Completed page 2 1 Yas 2 No certificete 1 ∏ Yes 2 ∏ No Division of Vital or Attending Physician: Be 25. Wes case rafarrad to medica! 26. Place of Death (Chack only ona) Hospitel: Certification: To 1 Yas 2 No Othar: 4₺ Nursing Homa 5 Rasidance 6 Other (Specify) 1 ☐ inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Daath 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural 5 Panding efter death.

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State Registrar 30. Nama ang

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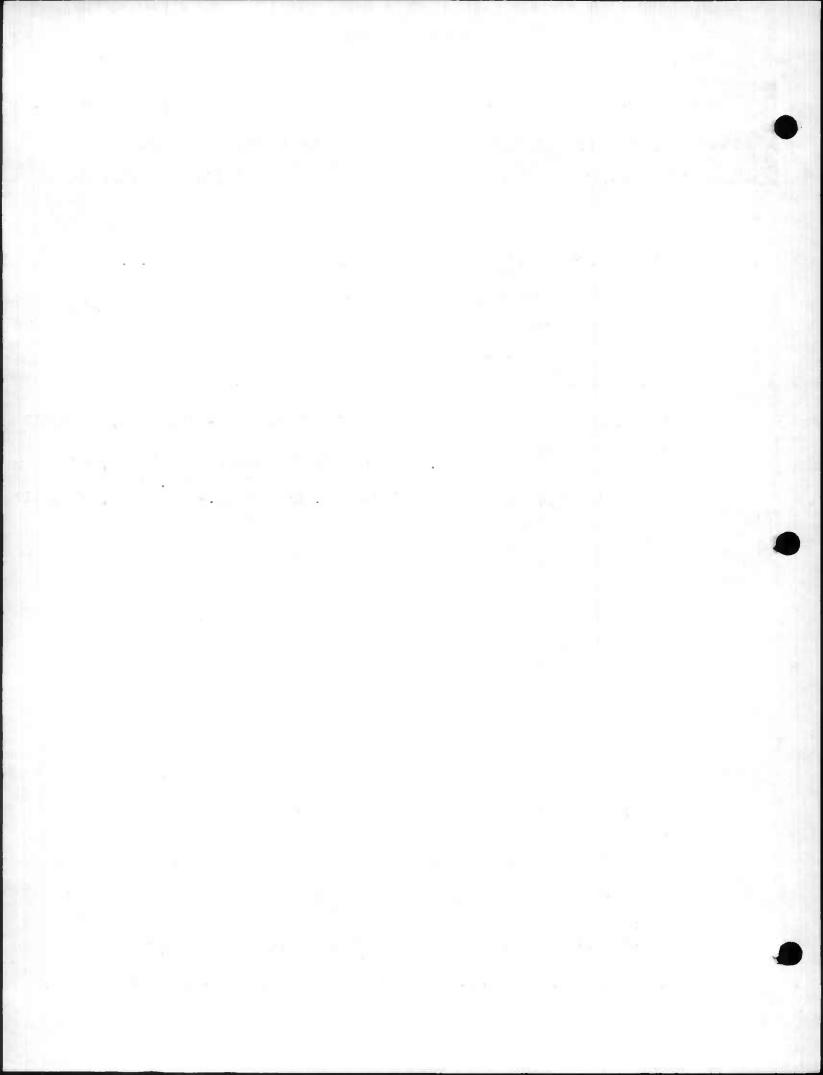
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address of person who completed cause of deeth (Itam 23e) (Typa, Print)



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Certificate of Death	Reg No	00

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1. Decedent's Neme (First, Middle, Last) Yeer Datrina February 25, 1998 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore
If Under 24 Hrs. Sinai Hospital of Baltimore

| Security Number | 6. Sex | 7. Age (In yrs. last birthday) If Under 1 Year Dete of Birth (Month, Dey, Year) //-2/-/972 Birthplece (State or Foreign Country) Months Deys Hours Min. 1 M 2 M F 25 Yrs. 216-82-5956 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Baltimore NA Md 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code Ridgewood 3814 Huenye 54 21215 Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien 11. Meritel Status Bleck, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Yes 2 No Specify: Specity: Black 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 1409 grade College (1-4or 5+)

NA Unknown Un Known 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) auton Quartes Jones Donnella 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sarah 3814 Grandmother Kidgewood 13a 140, mid Quartes 20b. Plece of Disposition (Name of cometery, cremetory or other plece) Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Memorial Park 4 □ Penetion 5 □ Other (Specify) 3-3-98 Arbutus Ma trowtus 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Jarch F. H. West Pert I, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. 4300 wabash fremme Immediete Ceuse (Finel disease or condition resulting In death) Brain Herniation Due to (or as a consequence of) Fall 3days Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): CNS Toxoplasmosis 10months Due to (or es e consequence of): AIDS 5years Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24e. Wes en eutopsy performed?

23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

> 24b. Were eutopsy findings eveilable prior to completion of cause of deeth?

2 No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner?
1 ✓ Yes 2 □ No

27. Manner of Deeth

1 Naturel

3 Suicide

29a, Certifier

2 Accident

4 Homlcide

(Check only one)

5 Pending

investigation 2/23/98 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 28b. Time of injury 28e. Dete of Injury (Month, Dey Year)

2 ER/Outpetlent 3 DOA Approx6pm

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

Fell down steps - seizure 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Battimore 3814 Ridgewood Ave. Maryland 212

Home

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner es steted.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated. 29d. Dete signed (Month, Day, Year) 29c. License number

AS2402321MP9522

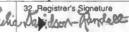
February 25, 1998

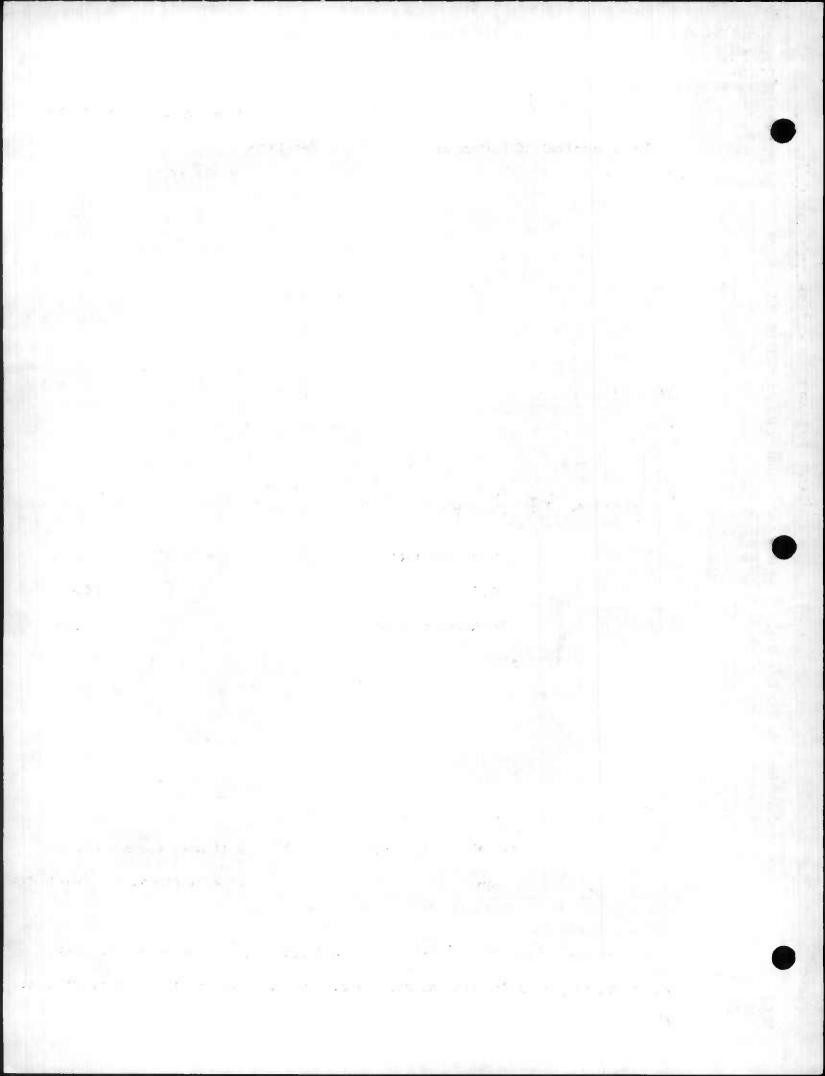
30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

Maria Prince, Sinai Hospital of Baltimore, 2401 W. Belvedere Ave. Balto, MD. 21215

31. Dete filed (Month, Day, Year)

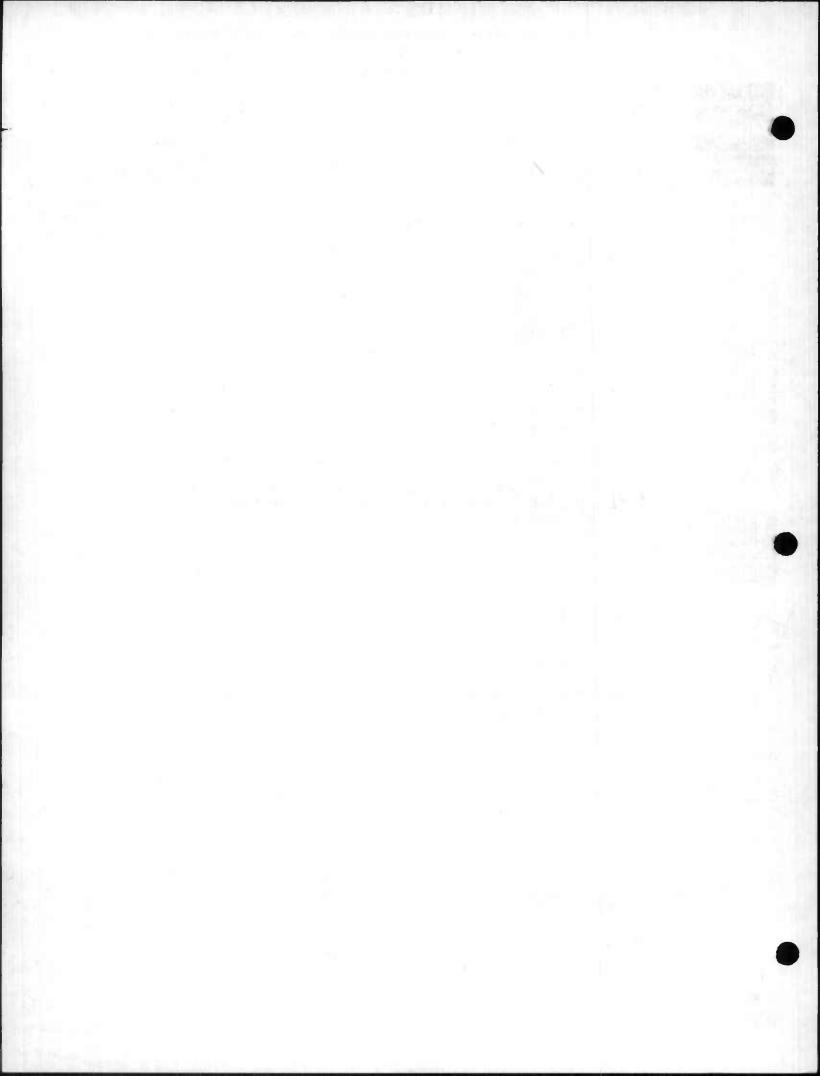
29b. Signeture end title of certified





State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Jarrard PRatt 03 3: 10 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Hospital Baltimore Johns Hopkins Bayview If Under 1 Year Months Days If Under 24 Hrs. E. Date of Birth Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** 1 M 2□ F 216-10-2426 82 Director 1915 Georgia May Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 Yes 2K No MD Baltimore Edgemere 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 2518 S. Snyder Ave 21219 USA itema 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after of the off Health and Mental Hyglene.
nt: If Itam 27 is marked other than "natural", or iter 1X Yes 2 No If Yes, Give Year or Detes: 43-45 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 Boat Builder Yacht Co. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be William Jarrard Bertha Bullock 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If Itam 27 is any Injury or other traugnos. 2513 Welsh Ave James H. Jarrard son Baltimore, MD 21219 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Mar. 7 1 ☑ Burlei 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Memorial 1998 Baltimore, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility
Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 23e. Pert1. Enter the dise ne, or complications that caused the death shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Ceuse (Final Hemorrhagic CVA 1 WK disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 6876 Physician/Medical The law requires that the death certificate 2 Due to (or es e consequenca of): Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Scizure d/o of Coronary outery dz. Records, þ sign sate has been si page 2 should Be Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Deecribe how Injury occurred 28b. Time of Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) MID 03-4-98 96712 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Baltimore 21224 Seo 4940 Eastern Are 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State who Davidson-Randall MAR 05 1998 Registrar

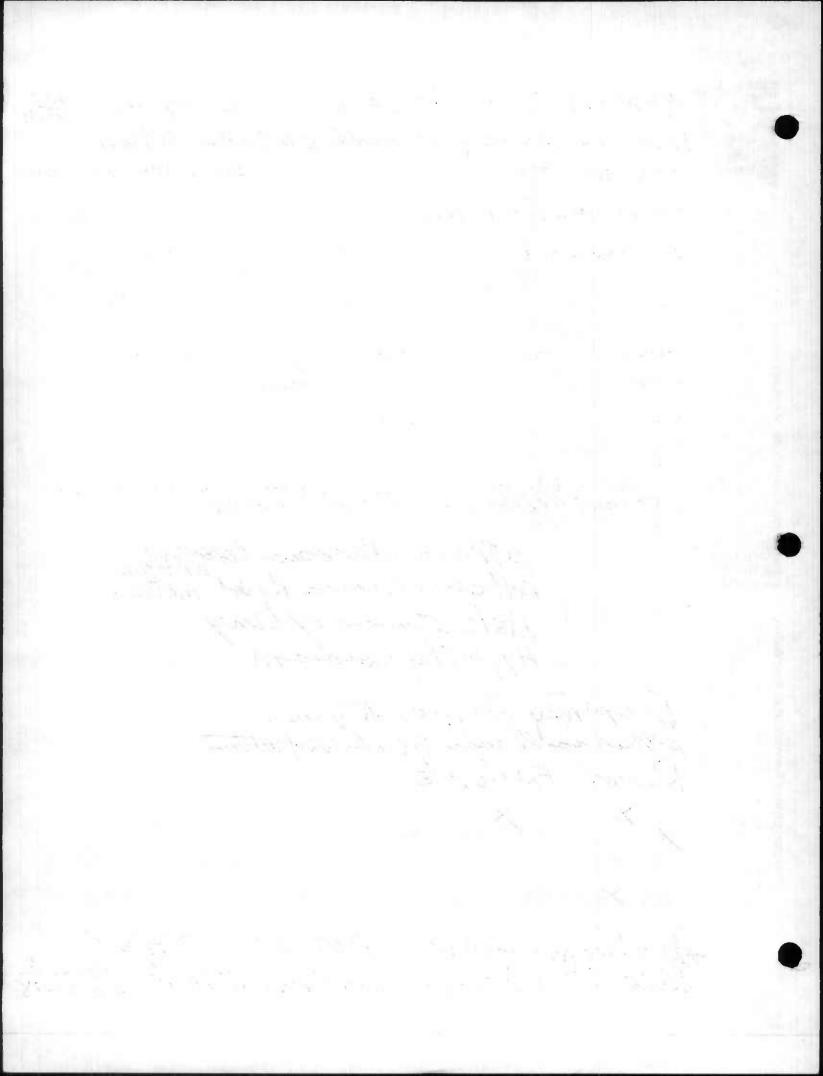


Item: 24a Per MD Film G-757 3-5-98RC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 0691

							ificate of	Death		Reg. No.	06941	3	
	hysici: /Medic xamin	al	1. Decedent's Name (First, Middle, La A Eacility Name (If not institution, giv	DW	JE	EN	KIN	4b. City, Town, op	2. Dete of D Month Location of Dee	Pay	3. Time of D	5 7 M	
	Admin	-	BONSECOU	RS HOS	P 200	wa	BALTO	BALI	IMORE	- BA/7	IMURE		
Dir	neral ector		5. Social Sacurity Number 6. S 245-05-0920 11	Sex 7. Age	(In yrs. lest birt		If Under 1 Yeer Months Days	if Under 24 Hrs Hours Min	8. Dete of Bi (Month, D June	18, 1918	9. Birthpleca (Steta or Country) North Car	Foreign colin	
Maryland	fied at	tor	10e. Stete 10b. County 10c. City, Town or Location									y Limits 2 No	
ith with the	ust be not	Funeral Director	10e. Street and Number 3310 Barrington Road 21215							10g. Citizan of Whet Country? U.S.A.			
5-0020 72 hours after death with the Maryland	important; it tem 4/1 is marked other trian. Patural, or tems 23s or 28s4 show any injury or other traumatic svent, the Maptical Examiner must be notified at once.	by	11. Maritei Stetus 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorcad	12. Wes Decadant Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:			is Dacadant of H 'es, specify Cubi Yes 2√√ No	lispanic Origin? (3 en, Mexican, Puel Specify:	Specify Yas or N rto Rican, etc.)		ca - Amarican Indien, ick, White, etc. 'Y: Black		
21215-0020 d within 72 hours af giena.	e Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondery (0-12)		eation during most of wo	orking		susiness/Industry					
yland 2 build be filed v Mentel Hygie	ed other	Be	unknown 17. Fether's Neme (First, Middle, Last) unknown	unknown	un	iknow	n	18. Mother's Ne		unknow e, Maiden Sumer			
and 2 should be file	r traumatic	To	19e. Informent's Neme/Reletionship (unknown		. Meiling . nkno				ber, City or Town, State, Zip Code)				
Baltimore, N pemit. Pages 1 and Department of Health	ry or othe		20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specification of the control o		isposition (Neme of crematory or other pleca) Date 20c. Location - City or Town, Si								
Baltim permit. Pag Department	any inju		21. Signeture of Funeral Service Licensee Renald S. Wade, Director State Anatomy Bord, 655 W. Baltimore Street Baltimore, Maryland 21201										
	dicai		shock, or heart feiture. List only Immadiate Ceuse (Finel disease or condition	one cause on each line.	ero	SC	lor	g, such es cargia	c or raspiratory	errest, WARU	Approximete Intervel Betw Onsat end De	een	
Exan		iner	resulting in deeth)	Athe	No Sc	conseque	ince of):	e R	ent "	ARTS	153		
68760, tificata be executed	as the buriel-transit	edical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	Asb	ue to (or as a o	ginseque	un	072	ung				
			resulting in daath) Lest	HYPE	The	11	ord	isn	1				
P.O. Hat the deat	hed for	Physician/N	Pert II. Sing significant conditions of	ontributing to death but	not rasuiting in	the unde	erlying cause giv	en in Pert i.	23b. Did	I tobacco use co	ontribute to the cause of	death?	
dS, P.	D 00	by	frem AR	y Ar	18-6	R	len	SION	,	Yes 2□No	3 ☐ Probably 4 ☐ U		
	ige 2 should	Completed	Pour 3	Fresh	0	C	eked,	KAJ au	CONT. POR	formed?	eveileble prior to completion of cau of deeth?	usa	
	tor, pa		25. Wes case referred to medical	MINO	THE			26. Plece of De	eth (Check only	Yas 2 No	1 ☐ Yes 2 ☐ N	10	
Division of Vita To the Hospital or Attending Physician: within 24 hours after death.	completely filled in by the funaral director, page	၉	examiner? 1 Yas 2 No 27. Menorer of Deeth 1 Neturel 5 Pending investigetion	Hospitel: 1 Ninpatient 28 Oate of Injury (Month, Dey)		tpetient Time of njury	28c. Injur Wor	er: 4 Nursing	Home 5□Res	idanca 6 Otl			
Divisi	ed in by the	Certification:	3 Suicida 6 Could not be determined 28e. Plece of injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number of Street) 28f. Location (Street end Number or Rural Route Number of Town, Stete)									er,	
To the Hospital or within 24 hours after	pletely fills	edicai	29e. Certifier (Check only one) Certifying Ph	ysician: To the best of r niner: On the besis of e and manner state	xemination end	, deeth od d/or inves	ccurred et the tin stigetion, in my o	ne, dete end piec pinlon, deeth occ	e, end due to the urred et the time	ceuse(s) end m , dete end piaca,	enner es steted. end due to the cause(s)		
To To Y	Coo	A	Signature and title of certifier	2 M	10		DZ S	a number	5	29d. Data signa 2//7/	d (Month, Day, Year)	11	
			OBERT	william	15 5.	Type, Pri	2 BAL	timore	notin	not ple	CATONSU	11/12	
R	Stat egistra	-	31. Date filed (Month, Dey, Year)	Sulia Ja Sana	s Signature								



Item: 24a Per MD Film G-757 3-5-98RC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death **Physician** Month Douglas Allen James 405am February /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fallston General Hospital Fallston If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1⊠M 2□ F 68 Vrs 217-24-9230 Director July 22, 1929 Baltimore Co.Md. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Harford Fallston 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5 2307 Harmony Terrace items 23a 21047 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 SYes 2 No Army
If Yes, Give Sept. 1946
Yeer or Dates: Dec. 1947 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, e filed within 72 hours after of Hygiene. Black. White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. 2 yrs. Heavy Equipment Industry Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Peges 1 and 2 should be famoust of Heeith end Mental Int: If Item 27 is marked or 10 Clinton Baker James Mary Bessie Perine 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Department of Heelth er Important: If Item 27 is any Injury or other traconce. Mrs.Annamarie R.James (Wife) 2307 Harmony Terrace Fallston, Md. 21047
Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) 1 ⊠ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Providence Methodist Cem.2/13/98 Baltimore, Maryland 21. Signature of Funeral Service & 22. Name and Address of Facility E. F. Lassahn Funeral Home
11750 Belair Road Kingsville, Maryland 21087

23a. Pert1. Enter the disease/ or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest,

Approximate Approximete Interval Between Onset end Death **Physician** PROSTATE CANCER Immediate Ceuse (Final disease or condition resulting in death) METASPATIC /Medical Examiner Due to (or as a consequence of) Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician end for use as the buriel-tran Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown UWEZ þ Completed 24a. Was an autopsy 24b. Were autopsy findings peen eveileble prior to completion of cause of deeth? performed? certificate has 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Piace of Death (Check only one) Hospitel: 1 Pinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No P After this 28c. Injury at Work? 27. Manner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred or Attending s efter dea...al Director: After 1 Maturei 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours of To the Funeral D 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the ceuse(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) end manner stated. edicai completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certife 29c License number

DHMH 16 Rev 6/95

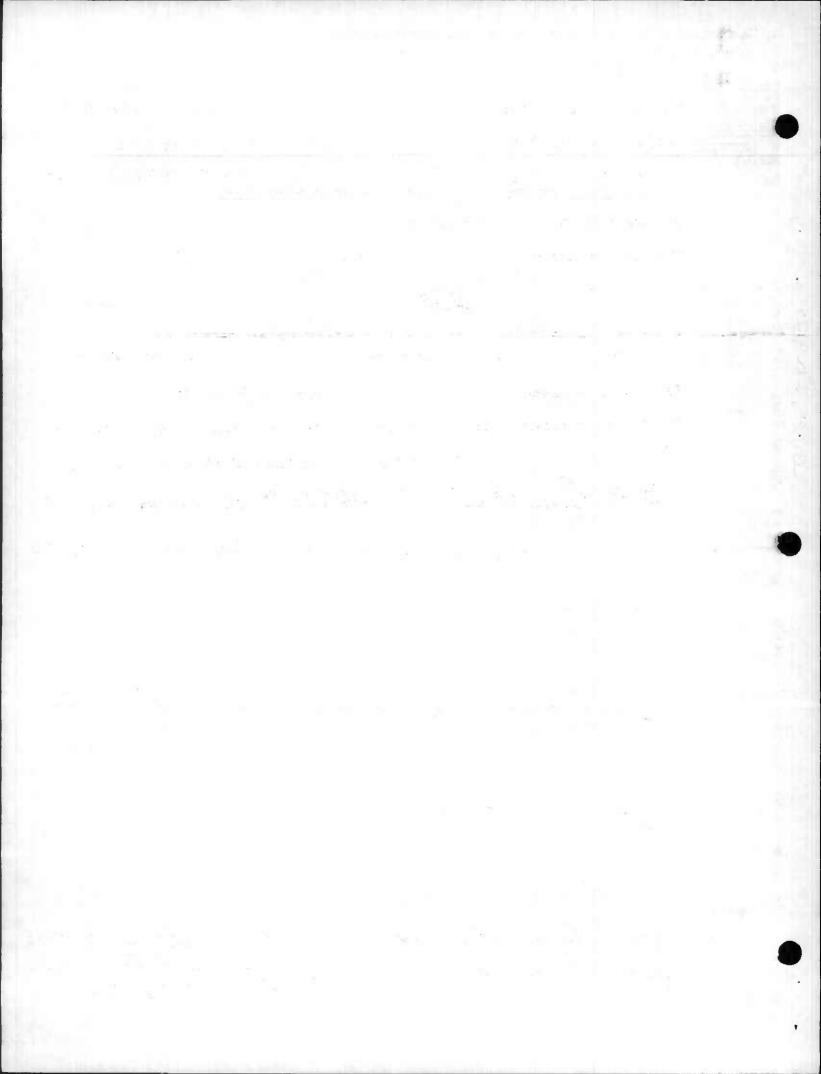
State

Registrar

31. Date filed (Month, Day, Year)

MAR 05 1998

12. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 9:50 Am Dey Louise I. Kaufman March 4b. City, Town, or Location of Death 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth 1712 St. Mary's Road Chester Queen Anne 5. Social Security Number 7. Age (In vrs. last birthdev) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Deys 1 ☐ M 2K F Months Hours 90 215-03-4996 May 17, 1907 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Oueen Anne Chester 1 ☐ Yes 2 X No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1712 St. Mary's Road 21619 United States 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2000 Specify: White 3€ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Ebon T. Butts Nettie Ingram 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 1712 St. Mary's Road, Chester, MD Ethel Byron / Daughter 20b. Plece of Disposition (Neme of 20e. Method of Disposition Date 20c. Location - City or Town, Stete Loudon Park Cemetery 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 3/6/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Lieensee 22. Name end Address of Fecility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 23a. Pert1. Enter the disees shock, or heart tailure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Intervel Between Onset and Death Immediete Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown Were autopsy findings available prior to 24a. Was an autopsy performed?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10e Stete

Funeral

Director

Show

7 is marked other than "natural", or items 23a or 28a-f shov treumatic event, the Medical Examiner must be notified at

Hygiene.

Peges 1 and 2 should be nent of Heelth and Mental

nt of Heelth a : If item 27 is or other tree

Department of important: If any injury or

Funeral Director

þ

Completed

Be

2

with the Meryland

death

filed within 72 hours efter

Baltimore, Maryland 21215-0020

P.O. Box 687

Records,

of Vital

Division

The law requires that the death certificete

or Attending Physician:

Hospital

death.

24 hours efter deat Funeral Director:

within 2 To the

completely

the buriel-tran USB as for deteched ned by pege 2 should be hes certificate director. this the funeral After

Physiclan/Medical Examiner A Completed Be Certification: To filled in by

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Part II. Other significant conditions contributing to death but set Titulting in the underlying cause given in Part I. completion of cause of death? t D Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) Manger Date of Injury (Month, Day Year) 28b. Time of how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f, Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) end menner steted. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, D

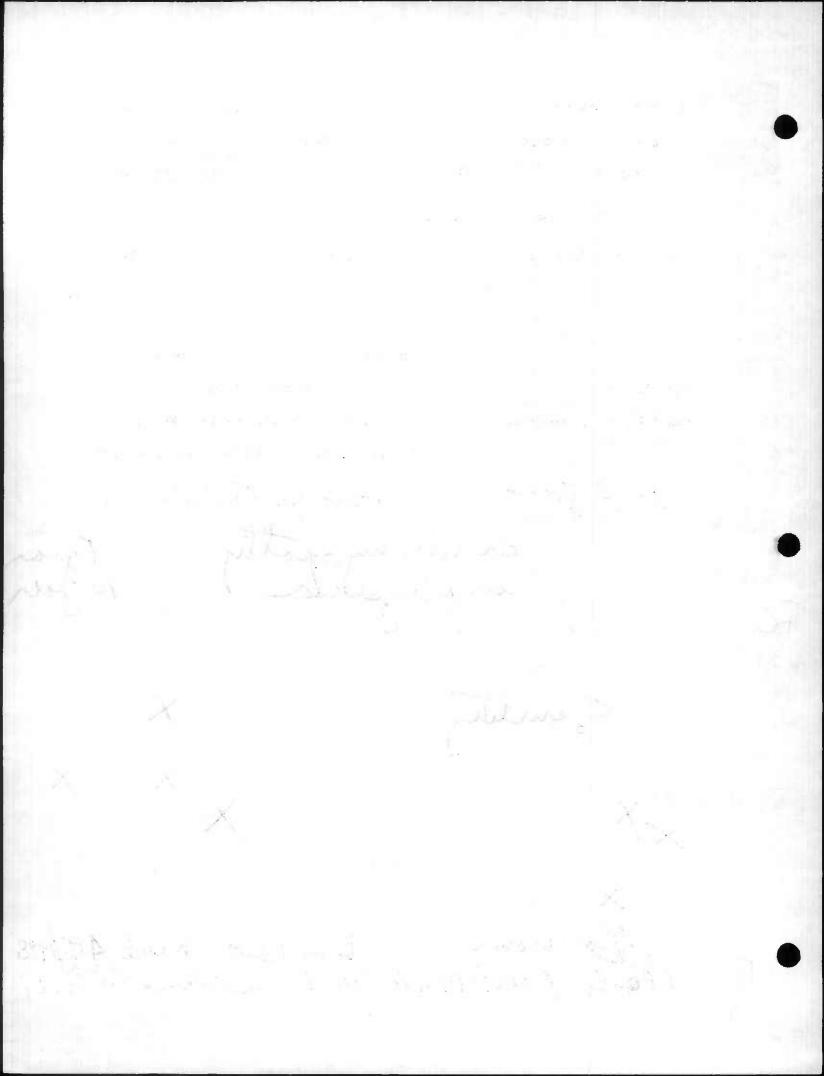
State Registrar

30. Nw

31. Dete tiled (Month, Day, Yeer)

0 5 1998

32. Registrer's Signature who Davidson nanuace

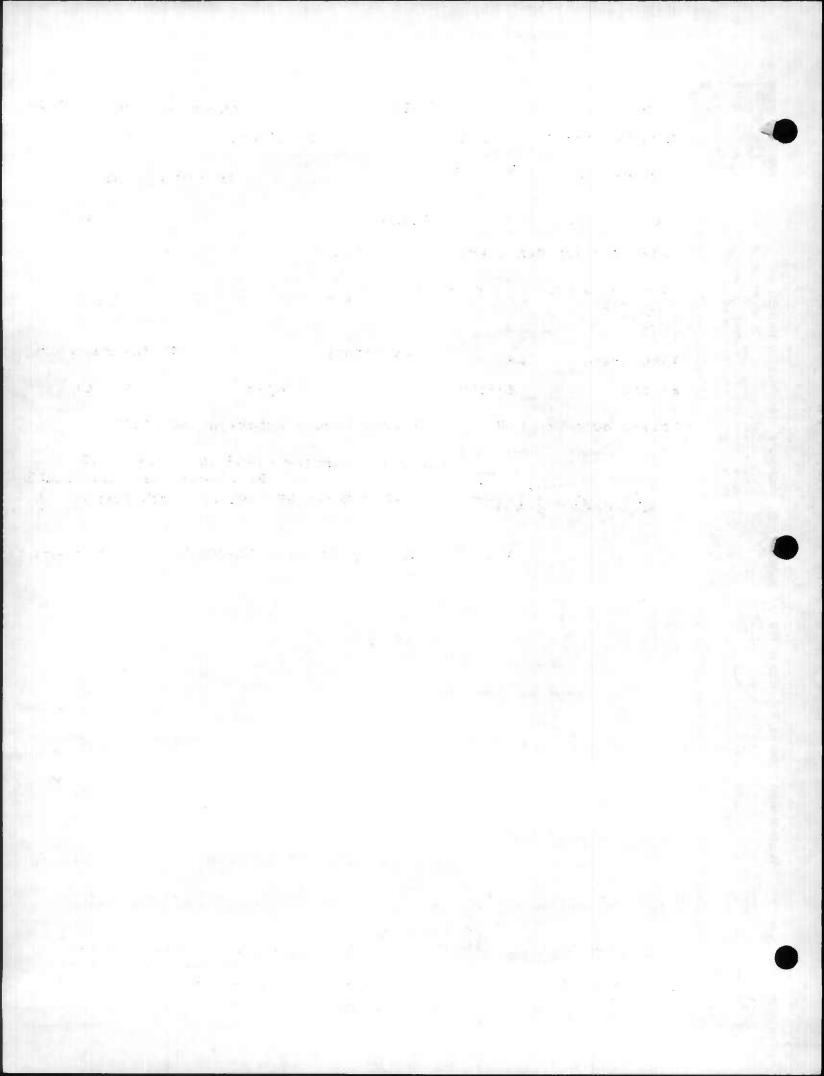


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 98 0695

				Ce	rtifica	te of	Death		F	Reg. No.	0 0	10891
	1. Decedent's Name (First, Middle, L	ast)							2. Date of Dee	9th Day	Year	3. Time of Death
Physician /Medical	Robin			Knigh	t				March	á -		4:45pm
Examiner	4a Facility Name (If not institution, g 2391 Perring						4b. City, To Balt		cation of Deeth	4c. Cou	inty of Deeth	
				for and the first bod and a	If I Indo	r 1 Year						only on Chata as Consider
Funeral Director	5. Social Security Number 6. 130-48-9450 Usual Residence of Decedent	Sex 1☐M 2∏x F	7. Age (In yrs. 39	Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Day 03-20		Ou NY	npiece (State or Foreign untry)
8 ts	10a. Stale 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
to to	Md. NA		В	altim	ore							x ¹ X Yes 2 □ No
r items 23s or 28s-f s rines must be notified Funeral Director	10e. Street and Number 2391 Perring	Manor	Road			Code	4			10g. Citlzen USA	of What Cou	untry?
Te 22	11. Maritel Stetus	12. Wes Deci	edent Ever in U	I,S. 13.	Was Dece	dent of I	lispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14. F	Race - Amer	
by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Gin Year or D	2 No		If Yes, spe		en, Mexicar Specify:	n, Puerto	Rican, etc.)		Black, White Black, Bl	a, etc. Lack
ygiene. Nor than "natural", It, fre Medical Exa Completed by	15. Decedent's	Education		16a. Dece	dent's Usu	al Occup	ation	t of work	ing	16b. Kind o	f Business/l	ndustry
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arks atte	Ashton	Kn	ight				Elo	oyse	2		Fi€	elds
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m 27 her ti	Dallas Woodwa	rd F.H						Broc	klyn,	NY 1		P 04-4-
Department of results are western hyperan "nature important: If flem 27 is marked other than "nature any injury or other traumatic event, the Medical page. To Be Completed	20a. Method of Disposition 1 Durlel 2 Cremation 3 4 Donation 5 Other (Special Control of Control		State	Place of Disponentery, cre ose Hi				03-	Date -06-98		den,	
Import any inj page	21: Signature of Funeral Service Lio	ensee	2				ess of Facilit		ltimor		_	and 21202 enue
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sician acica miner	Immediate Cause (Final disease or condition	M	ETAST	ATIC	GI	AST	RIC	. c	ANCE	R	1	6 HONTHS
ig Maria	resulting in death)		Due to (or as a conse	quence of)):						
inel-transit	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or as a conse	quence of)	:						
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he et he d fo	Part tt. Other significant conditions	contributing to de	eath but not res	sulting In the u	underlying	cause gi	ven in Part i	i.	23b. Did	tobacco usa	contribute	to the cause of death?
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shoul shoul									24a. Was perfo	an autopsy rmed?		Were autopsy findings evailable prior to completion of cause of death?
certificate hes rector, page 2 Be Comp									10	Yes 2010		1 □ Yes 2 No
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of Director: After the in by the funeral Certification:	27. Manner of Death 1 MNeturel 5 ☐ Pending 2 ☐ Accident investigati	ion	of Injury th, Day Year)	28b. Time o	of M	28c. Inju Wo 1 □	ryet rk?]Yes 2∐		28d. Describe l			
od in by	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	200. Place	of Injury - At hing, etc. (Speci	ome, farm, st	reet, fecto	ry, offica			28f. Location (: City or To		umber or Ru	iral Route Number,
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n 24 nou ne Funer pletely fill edical	(Check only 2 Medical Expone)	Iljas	FELLOW					7-5				, 1998 STREET



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 1998 7:45 p.m. **Physician** David Jerome Luchau /Medical 4e Fecllify Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9302 Groffs Mill Drive Owings Mills Baltimore If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 16,1930

9. Birthplace (State Country)

Minnesota 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 F 67 478-28-8630 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Md. Baltimere Owings Mills Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with than "naturel", or items 23s or U.S.A. 21117 9302 Groffs Mill Drive Funerai death 12. Was Decedent Ever In U.S. Arged Forces?
1.246-11.45 2 No. 1.946-11.45 No. 1.966 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Stetus filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 1966 A 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiane. Staff Sargent U.S. Marine Corps 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 and 2 should be fount of Health and Mental Int: If them 27 is marked of Leone Hurley Walter Luchau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 9302 Groffs Mill Drive, Owings Mills, Md. 21117 Marian L. Luchau Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) = 3 permit. Pege Department Maryland Veterans Cem. Mar. 6, 1998 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Part1. Errier the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel 17 months Caremone Colon disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physician and the burial-transit deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lasl Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): 88 esn ō signed by the e 23b. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 100 þ The law requires 24b. Were eutopsy findings available prior to completion of ceuse of death? been si Completed 24a. Was an autopsy s certificate has b director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 No Ittending Physician: director, Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4□ Nursing Home 5 Desidence 6 □ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funerai 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Watural 1 Tyes 2 No death. 2 Accident ctor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide or 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steled.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 36986 MD

nulwn

who Davidson-Randall

mstrong

82. Registrar's Signature

600

N. Wolfe St

Baltimere MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1998

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State Registrar

Deborah 31. Date filed (Month, Day, Year) . n.c. 3, 120. 5:15 0.0. whether elife elected Arron 16, 3 30 Managete c. .nltimore 11. 21112 musco entrett .d.t. damment treatment rater Loon

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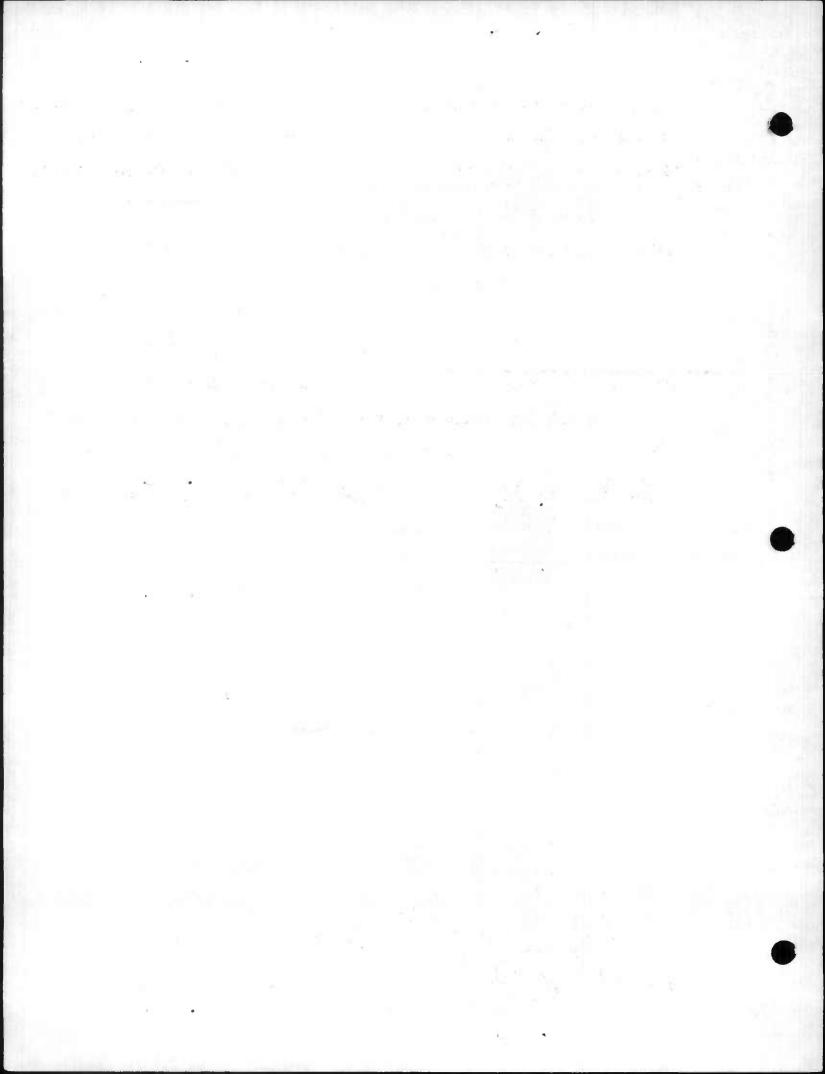
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				Otate of Mai	ylaliu / i		ficate of			eg. No.	8 0	6953
Г	Dhysici	ian	1. Decedent's Name (First, Middle, La						2. Dete of Deet Month	h Day	Year	3. Time of Death
	Physici /Medic		Beatrice Lo	uise Mars	hall				March	1, 19	98	9:00 AM
1	Examir	ner	4e. Facility Name (If not institution, giv Manor Care To				ľ	4b. City, Town, or Lo TOWSON	ocation of Death	4c. County Bal	of Death timo	re
	Funeral Director		5. Social Security Number 6. S 163-24-8615	6ex 7. Age (□ M 20XF 6 8	In yrs. last bii		f Under 1 Year Ionths Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Feb. 22	, 1930	9. Birthple Count Penns	ece (Stete or Foreign ny) Sylvania
	/land		10e. Stete 10b. County	1	0c. City, Tow	n or Locat	ion				10	d. Inside City Limits
	Men all sh	to	MD Baltim	ore	Bal	timo	re					1 ☐ Yes 2 No
	th with the 23a or 28	al Director	10e. Street and Number 1618 Providen	ce Road			10f. Zip Code 21286		1	0g. Citizen of V		ry?
020	72 hours efter deeth with the Maryland "natural", or items 23s or 28s-f show addest Exactinet must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Even Armed Forcas? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates:	er in U,S.		S Decedent of Hes, specify Cube	lispanic Origin? (Spe en, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, e .: Whi	tc.
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lan	S S S S	To Be	Charles Henry				1	Beatri			,	
ary	S D E E	F	19a. Informant's Name/Relationship (191	b. Mailing A	Address (Street	end Number or Rura				Code)
	nd 2		Arthur M. Marsha	ll, Sr./Hus								
Baltimore,	一工 5 号		20a. Method of Disposition 1 XBurlal 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	nemoval from State			on (Name of ory or other plea Cemete		rch 4.	20c. Location - reela	•	
Balt	permit. Pages Department of Important: If I any injury or once.		21 Signatule of Funeral Service Licar	Shart I		J. N J. N 24	ame end Addre	ss of Facility tenstein d St., Ne	Mortu	ary,	INC.	7349
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	Examiner	Jer	disease or condition resulting in death)	e. Di	le to (or as a	conseque	nce of):				2	- W
ox 68760,	certificate be executed rding physicien and use as the buriel-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	· A.S	e to (or as a	·V					4	wks.
Box	the death y the atter sched for u	Iclar	Part II. Other significant conditions of	ontributing to death but r	not resulting l	n the unde	rhino cause oiv	en in Red I	23h Did to	hacco use co	ntribute to	the cause of death?
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	To the Hospital within 24 hours e To the Funeral Completely filled	edical	29a. Certifier (Check only one)	ysician: To the best of n lines-On the basis of ex and manner states	aprination <u>an</u>	, death oc d/or invest	curred at the tining igation, in my o	ne, date and placa, a pinion, death occurr	and due to the ca ed at the time, d	ause(s) and ma ate and place,	nner as sta and due to	ited. the cause(s)
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Baltimore, Maryland 212	
. Box 68760,	
Vital Records, P.O.	
Division of	

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	-				Cer	tificate	of L	Death			Reg. No.	5 1	16954
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는 다음 다		4 Inomicide	28e. Plece of Injury building, etc. (City or Te	own, Stete)		
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6		30. Neme end eddress of person who con ABOUL WAITER		th (Item 23e)	(Type, F	Print) 4KH1	()	WE.	HA	CERST	2-24	921	742
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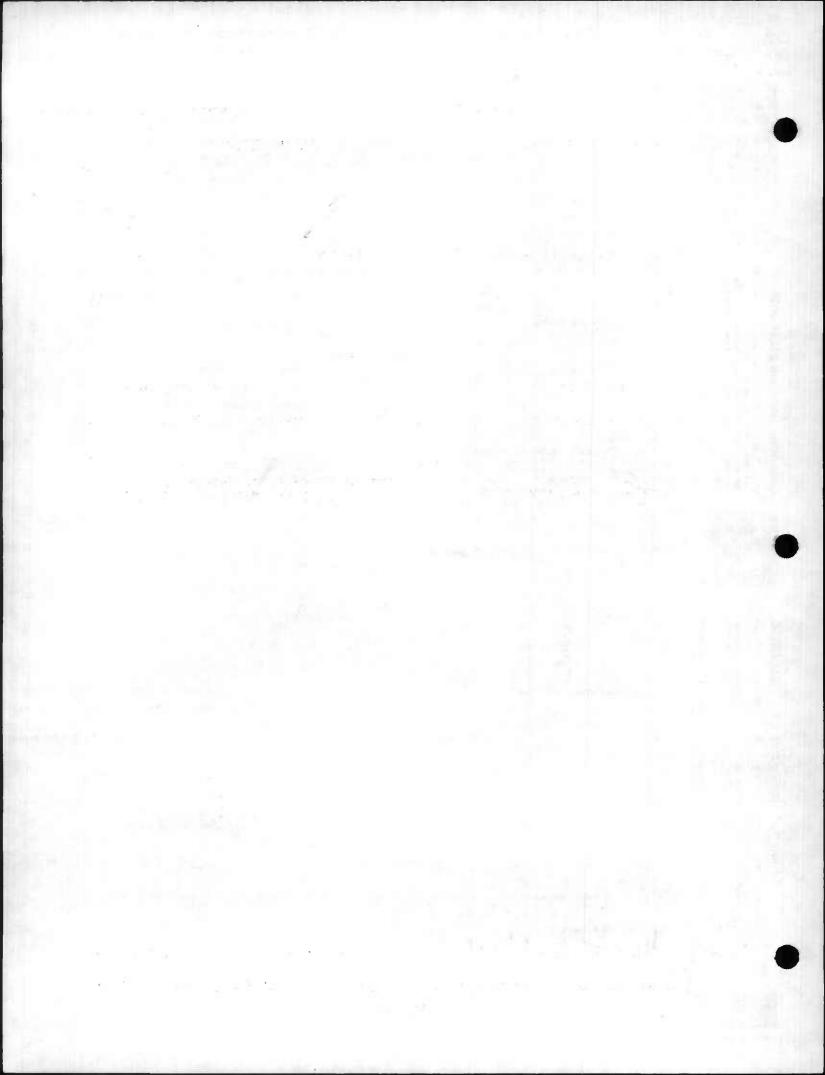
JAY L. MELTZER

State of Maryland / Department of Health and Mental Hygiene

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Fur	neral	5. Social Security Number	6. Se	ex 7.	Age (In yrs.	last birthday)	If Undar 1 Y Months Da	ear I	f Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D		9. Birth	placa (Stata or Foraig
	ector	263-57-047	2	M 2□F	37	Yrs.	Months	ays	Hours Will.	OCT 21	, 1960		Jersey
and		Usual Residence of Deceder 10a. Stata 10b. C			10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
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th the	iner must be noticed Funeral Director	10e. Street and Number				27	10f. Zip Cod	de			10g. Citizen of	What Cou	intry?
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980 7	alle all	11. Marital Status		12. Was Decede Armed Force		,S. 13. \	Was Decedent f Yas, specify	of Hisp Cuban,	anic Origin? (Sp Maxican, Puerto	ecity Yes or N Rican, etc.)	o- 14. Rad Blad	e - Amer ck, Whita	icen Indian, , atc.
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of Health	othe	20a. Method of Disposition			20b. F	Place of Dispo	sition (Nama o	of r place)		Date	20c. Location	City or 7	Town, State
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1	1	Mounte	Ilh	rel/h	U			o.c.	M.E.		MARCH	02.	1998
		30. Name and address of p	rson who c	completed ceusa o	of daath (Itan	n 23a) (Type,					1 2 31 (011		
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Registrar

MAR 0 5 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** JAMES MCALLISTER 1998 0345 Hrs MARCH /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** HOSPITAL RANDALLITONN BALTIMORE 7. Age (In yrs. last birthday) H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) | 1 Year | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hours | 1 Hou 5. Social Security Number Birthplace (State or Foreign Country) 100 M 2□ F 218-36-3221 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Director 1 Nes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5509 Northaneen U.S.H 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: by Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired). 16b. Kind of Business/Industry Cab Company Elementary/Secondary (0-12) College (1-4or 5+) grade Cab Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hart Herbert 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5509 Northgreen Balto, red Road WWT 20b. Place of Disposition (Neme of gemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Glan 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. wabash grenue Immediate Cause (Finel disease or condition resulting in deeth) DILATED CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HIVER FAILURE 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Appatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Records, Division of Vital or Attanding Physician: this After death. To the Hospital or Attance within 24 hours efter deatl To the Funeral Director: Completed by Physician/Medical Examiner

Be

Certification: To

Medical

Funeral

Director

28a-f show

Items 23a

the Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iten any Injury or other traumetic event, the Medical Examine BORS.

Physician

/Medical

Examiner

Maryland 21215-0020

Baltimore,

Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homleide

29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

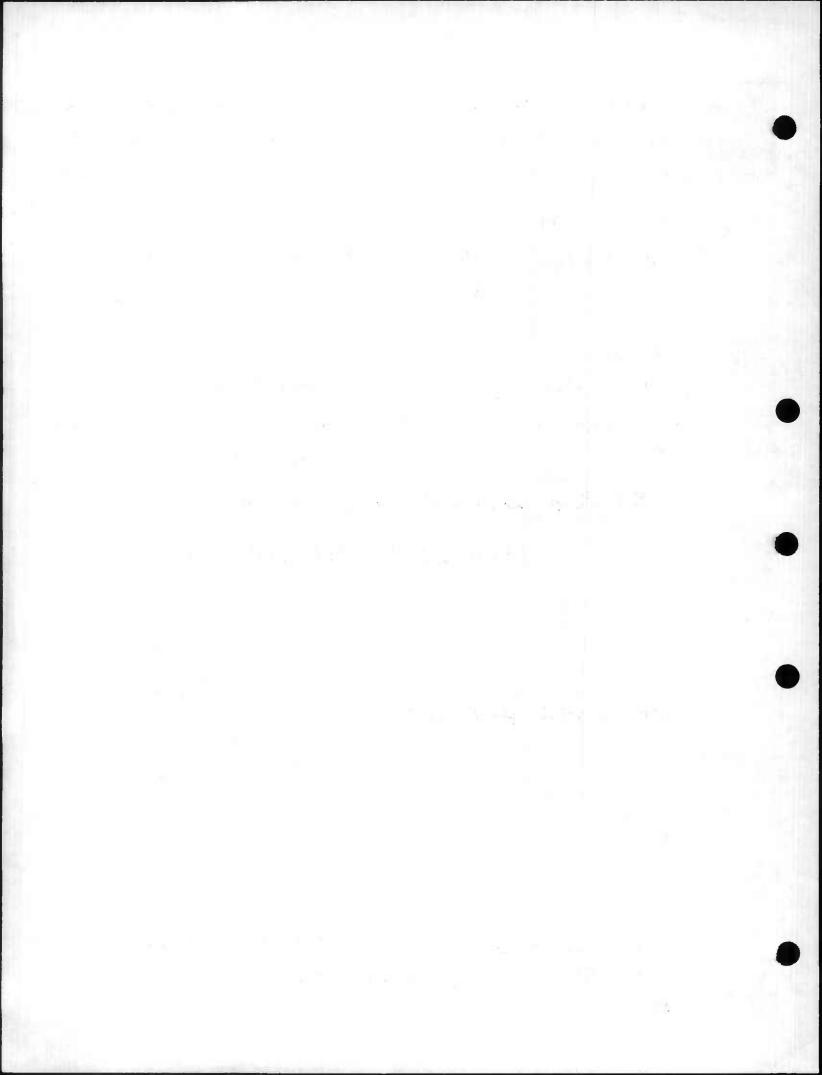
29c. License number 29d. Date signed (Month, Day, Year) D37333 MARCH 2nd 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MO, NHC, BALTO. MO 21133

Registrar

32 Registrar's Signature

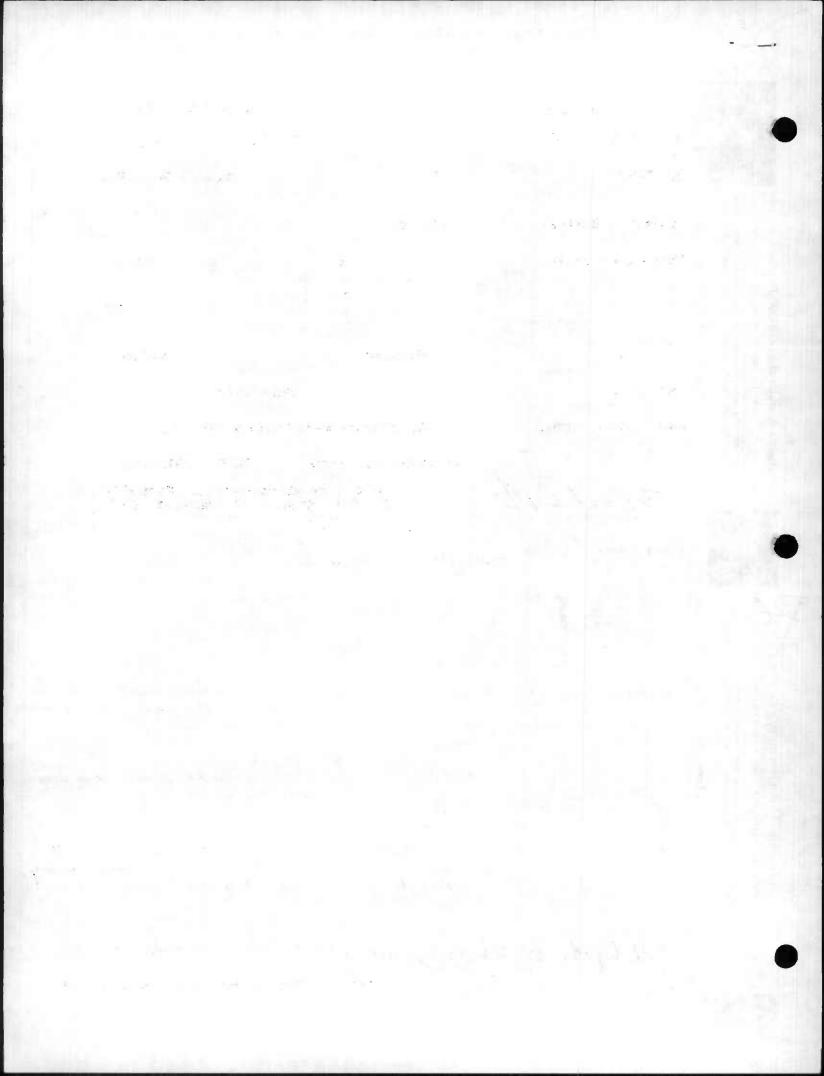


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22. Name and Address of Facility 22. Part I. Signature of Funeral Service Licensee Part I. Signature of Funeral Service Licensee Part I. Signature of Funeral Service Licensee Part I. Signature of Funeral Service Licensee Part I. Signature of Funeral Service Address of Facility 22. Part I. Signature of Funeral Service Barbox, or hard feature. List only one cause on seek line. Part II. Signature of Funeral Service Barbox, or hard feature. List only one cause on seek line. Part II. Signature of Funeral Service Barbox, or hard feature. List only one cause on seek line. Part II. Other signature of Funeral Service Barbox, or hard feature. List only one cause on seek line. Part II. Other signature of Funeral Service Barbox, or hard feature. Part Underlying Cause. Enter Underlying Indicate Cause. Enter Underlying Indicate Cause. Enter Underlying Indicate Workship I. Signature	1X Buriel 2 □ C	Cremation 3 □F		9 0	emetery, ci	rematory or	other pla						
Part II. Other algoritions contributing to death but not resulting in the underlying cause given in Part I.				St.				-	3-2-98	Ba1	timore	e, MD	
23a. Part. Enter the disease, or complications in tal caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feature. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or	21. Signature of Punel	Tal Service Licens	11-			Bradle	y-Ast	ton-Dabrow	rski-Matth	ews F	uneral	L Home,	Inc.
Onset and Deal Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 1 Yes 28 No 3 Probably 4 Unit 1 Yes 28 No 3 Probably 4 Unit 24e. Was an eutopsy performed? 25. Was sease referred to medical esaminer? 1 Xi ves 20 No 1 25. Was sease referred to medical esaminer? 1 Xi ves 20 No	23a. Part 1. Botter the	disease, or comp	lications that cause	ed the deat	h. Do not e	enter the mo	de of dyl	ng, such es cardia	ac or respiratory	errest,	A. Marie	Apr	proximate
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30. Name end address of person who completed cause of death (Item 23a) (Type, Print)	examiner? 1 XYes 2 No 27. Menner of Deeth 1 Natural 2 X Accident 3 Suicide 4 Homicide 29a. Certilier (Check only one)	5 Pending Investigation 6 Could not be determined	28e. Date of In (Month, D. 28e. Place of Inbuilding, decian: To the besiner: On the besis	jury ley Year) 98 njury - At he etc. (Specif 51 t of my kno of examine	28b. Time Injury 072 ome, farm,	of 2 9 M street, factor ath occurre investigation	28c. Inju Wo	her: 4 Nursing iny at rk? Yes 287 No	Home 5 Red 28d. Describe 28d. Location City or T. Balt me 2e, end due to the	sidence how injut (Street a own, State e couse(s o, date an	6 Other uny occurred not Number of During Number of During State of the state of th	or vel er or Rural Ro 1 dal K 1, Man nner es states and due to the	yland d. cause(s)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 3 1998 1 AM MARY EVELYN 4a. Fecility Neme (ff not institution, give street end number) 4b City, Town, or Location of Death 4c. County of Death General Makyland 5. Sociei Security Number Baltimore 7. Age (In yrs. last birthday) if Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 1□M 20F Deys 2/4-/2-276/ Usuel Residence of Decedent 85 Yrs. 10e Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 11 Tas 2 No 10e. Street end Number BALTIMOIE 10g. Citizen of Whet Country? Flowerton Kupo USA 4262 11. Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. Never Married 2 Merried 1 ☐ Yes 2 Mo If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done do life_DO NOT use ratired) during most of working Elementery/Secondary (0-12) College (1-4or 5+) LAUNOVY DUMESTIC 64 Grade 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) PAYNE WSEPh 19b. Mailing Addrass (Street end Number of Rurel Route Number, City or Town, Stete, Zip Code) 2/2/8 19a. Informent's Nama/Ralationship (Type, Print) 816 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 50 N 20c. Location - City of Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removel from State moststown, naryloxx 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility CNA TARA - HAVI'S 21. Signeture of Funerel Service Licensee BAHDRESTEVSTOUND RUANS Ya 23a. Part Enter the disease, or complications that ceused the daeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediata Ceusa (Finel diseese or condition rasulting in death) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted avants resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given In Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 2 DINO 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpetlent 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred

/Medical Examiner Box 68760, Records, P.O. Division of Vital

Physician/Medical Completed by Be Certification: To

Medical

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinal must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Haaith end Mental Hygiene. Important: If item 27 is merked other than "natural", or iter any injury or other traumatic event

Physician

Baltimore, Maryland 21215-0020

physicial the buria 98 signed by t this certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p

State Registrar

25. Was case referred to medical exeminar? 1 Yes 2 No 27. Menner of Daath 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 28e. Place of injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a. Certifier (Check only one)

**Cartifying Physician: To the best of my knowledga, deeth occurred et the tima, deta and place, and dua to tha ceusa(s) and mennar es stated.

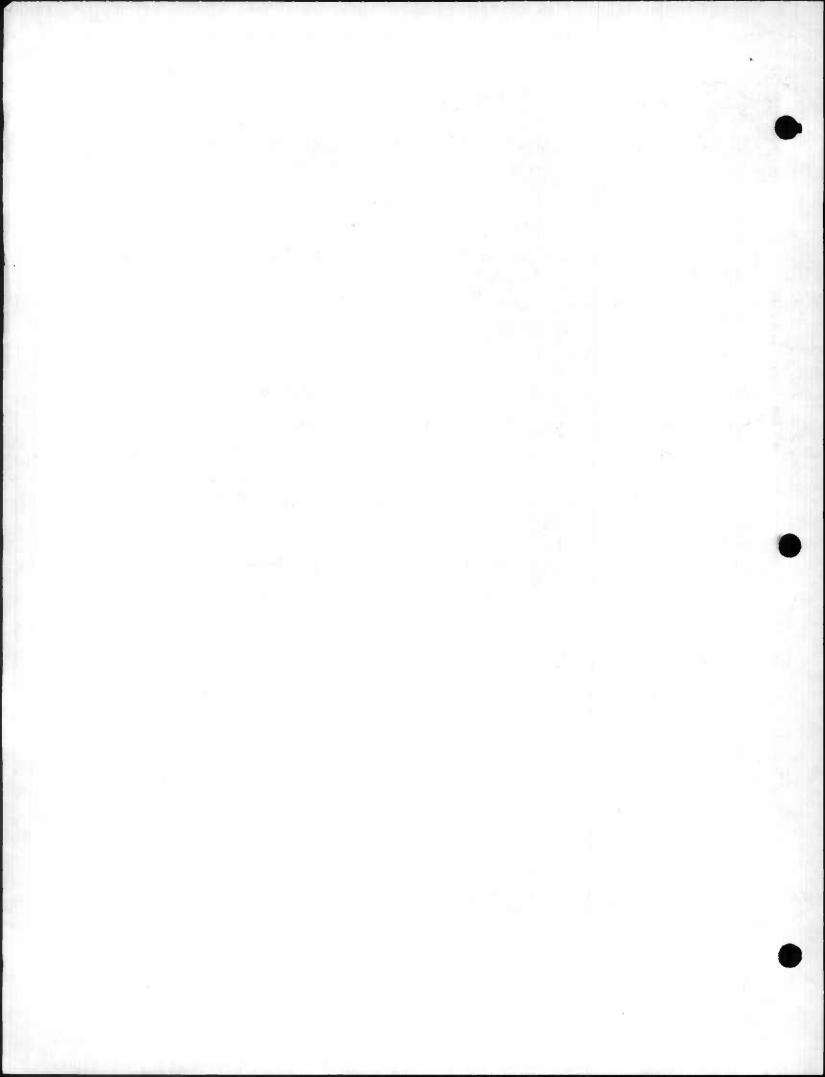
2 Medicel Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

MD

30. Name end eddrass of person who complated cause of deeth (Item 23a) (Type, Print)

M.D. Nou hao

31. Date filed (Month, Dey, Year) MAR 05 1998 was audson



State of Maryland / Department of Health and Mental Hygiene

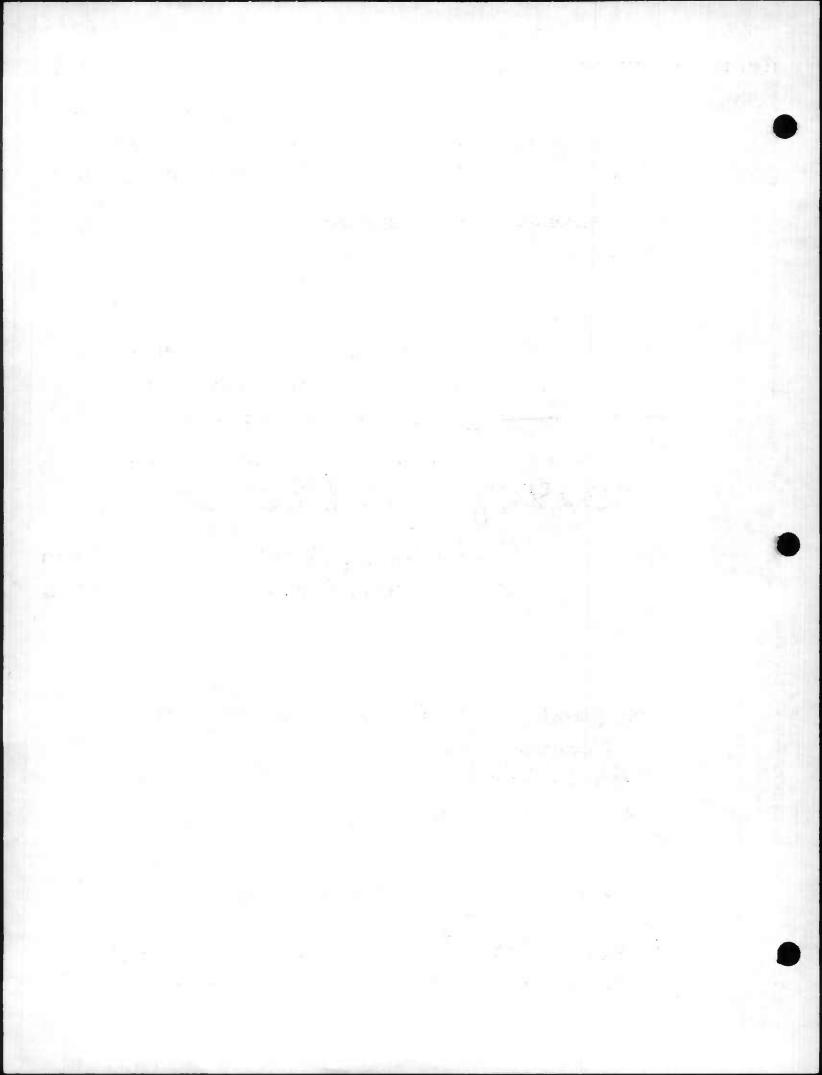
Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth **Physician** PAVL BERNARD 8:50 PM MARCH 198 /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINA HOSPITAL OF EXITIMORE BALTIMARE N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Days Hours X M 2 F ZZO-ZZ-318 Yrs Director JUNE 16,1924 MARYLAND Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo MARYLAND BALTIMORE BALTIMORE 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 16 OLD COURT ROAD, APT. 217 21208 115a Funera 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 PROPRIETOR PAULS LIQUORS other pemit. Peges 1 end 2 should be filk Department of Health end Mentel Hy Important: If Itam 27 is marked other any Injury or other traumatic avant 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surname) Be JOSEPH PAUT. HELEN BLUMBERG 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. SHIRLEY PAUL (WIFE) 16 OLD COURT RD, APT. 217 BALTIMORE, MD 21208 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State HEBREW YOUNG MENS -3-3-1998 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarai Service Licensar 22. Name and Addrass of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208 23a. Parf. Enter the disease, or complications that ceused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batwaan Physician /Medical Immediate Cause (Final disease or condition resulting in death) SEPSIS Examiner Due to (or as a consequence of): Physician/Medical Examiner RENAL DISEASE ON HEMODIALYSIS Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Causa (Disaase or Injury that Initiated evants rasulting in death) Last HYPERTENSION Due to (or as a consequence of): attending p NON INSULIN DIMBETES MELLITUS Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.0. 23b. Did tobecco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Vnknown COCONATRY ATTERLY DISEASE Records, þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed Deen Peripheral VASCULAR DISCASE hes 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Rastdence 6 Other (Specify) 10 27. Manner of Death 28b. Time of Certification: 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F after death. I Director: After After 1 Naturat 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide c To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, end dua to the cause(s) and manner es stated.

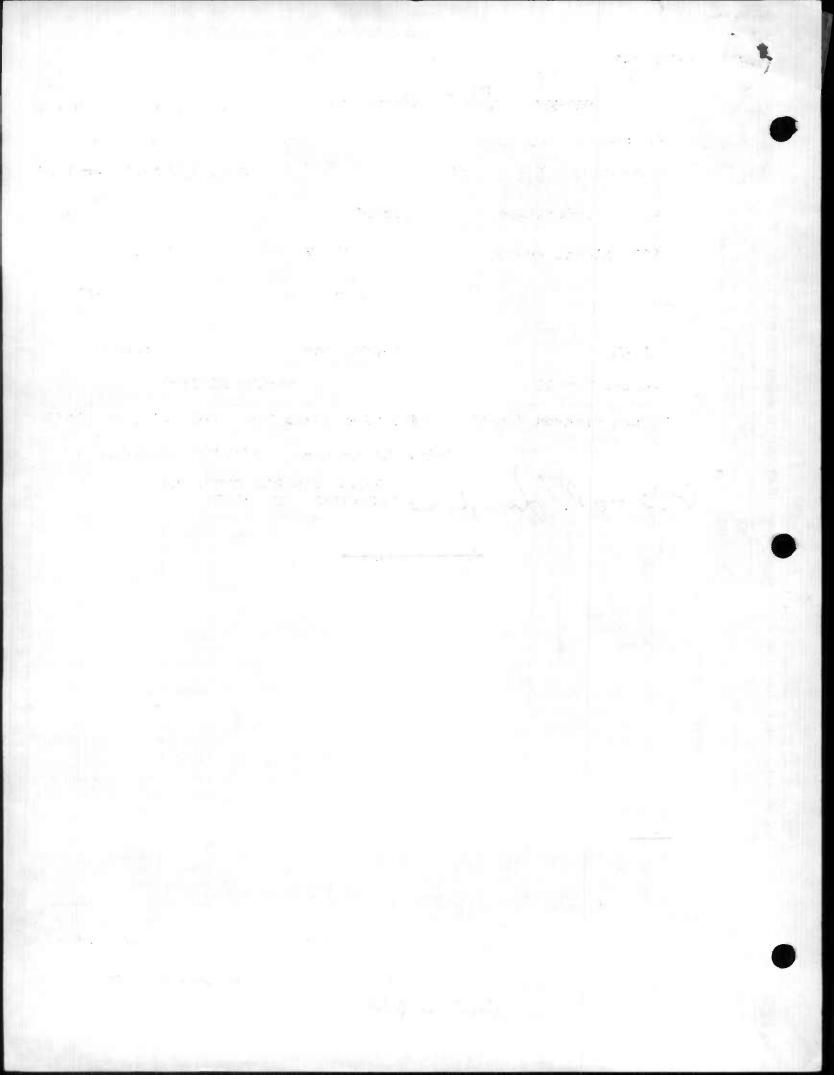
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signatu 29c. Licensa number 29d. Date signed (Month, Day, Year) AS2402321-VH9519 MKRCH 30. Nama and address of derson who complated cause of death (Item 23a) (Type, Print) 2401 WEST BELVEDERE AVE JENNIFER HALPERN SINAI HOSPITAL BANTIMORE MD 21215 JENNIFER HALPERN BATIMORE MD 31. Date filed (Month, D 32. Registrar's Signature State hie Vavidson-Randale Registrar

State of Maryland / Department of Health and Mental Hygiene Item: 19a Per FH Film G-758 4-2-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death **Physician** Month Day Veal E. Robert. Plack. 1998 /Medical March 9:30AM 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cambridge

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Deys | Hours | Min. | May 19, Dorchester General Hospital Dorchester 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthdey) 9. Birthpiece (State or Foreign **Funeral** Pennsylvania 82 Yrs. Director 190-05-5437 Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** Talbot Maryland Trappe 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ŏ 29292 Maple Dr. 21673 USA Items 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0020 ò 1 ☐ Yes 2 No by Specify: Specify: 3 N Widowed 4 □ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Departmant of Health end Mantal Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, tra M. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Machinist Civilian Naval Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Elmer Plack Sandmaier Α. Anna Marie 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathryn Schult (Daughter) 29292 Maple Dr. Trappe, Md. 21673 GRANDDAUGHTE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 3/5/98 Grandview Cemetery Johnstown, Pa. 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name and Address of Facility
Stallings Funeral Home P.A. Hilary L Stallings 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical lmonary **Examiner** Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest pue the burial-tren Due to (or as e consequenca of) Box 68760 ettending physician Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be datac 3 □ Probably 4 □ Unknown 1 Yas 20 No þ Be Completed 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? After this certificate has Trial 2 NONO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 20€R/Outpatient 3□ DOA Medical Certification: To funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? il or Attending P sefter deeth. I Director: After t 1 Daturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homiclde To the Hospital
Within 24 hours e Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner as stated.

2 Medical Exeminer: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 49/6/91 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Cambridge 20 31. Date filed (Month, Day, Year) Registrar's Signature State Daydson-Handall MAR 05 1998 Registrar





Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Name (First, Middle, Last) 2. Date of Death 26, **Physician** : 11 **FEBRUARY** 1998 /Medical 4a. Facility Name (III por institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deel **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 5. Sociel Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 20 F Months Days Hours Min Yrs. Director 212-32-4838 April 9, 1935 Maryland Usuai Residence of Decedent with the Maryland 10a State ehow 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at 1 XYes 2 No Director items 23a or 28a-f Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 3102 E. Lombard Street 21224 U.S.A. death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 11 Maritai Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married 8 1 ☐ Yes 2 X No Specify à 3 ☐ Widowed 4 ☐ Divorced Year or Dates "naturel", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Eiementary/Secondary (0-12) Coilege (1-4or 5+) 9 Own Home Homemaker permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is merked other any Injury or other traumation. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 William Thomsen Anna Alt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Prietz / Husband 3102 E. Iombard Street Baltimore, MD 21224 20e. Method of Disposition 20b. Piace of Disposition (Name of cometery, crematory or other place) Dete 20c. Location - City or Town, State 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Moran-Ashton-Dabrowski Funeral Home, Inc. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, and one cause on each line. 3000 E. Baltimore Street Baltimore, MD 21224 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximate interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Physician/Medicai the the ettending phy USB BS Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown been signed þ 99 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24a. Was an eutopsy performed? certificate hes 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Avatural 2 Accident 5 Pending investigation death. 1 Yes efter death Director: 3 ☐ Suicide 6 Could not be determined in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours el To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated. Medical 29e. Certifier (Check only one)

Division of Vital Records, P.O. Box 68780
Hospital or Attending Physician: The law requires that the death cardifices

Baltimore, Maryland 21215-0020

29c. License number

29d. Date signed (Month, Day, Year)

MS

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Temporary 26h 188

30. Name and address of person who completed bause of death (Item 23a) (Type, Print)

OURS APPRINS FOSATAC 600 N Wolfe St Rolfimore MD 21287

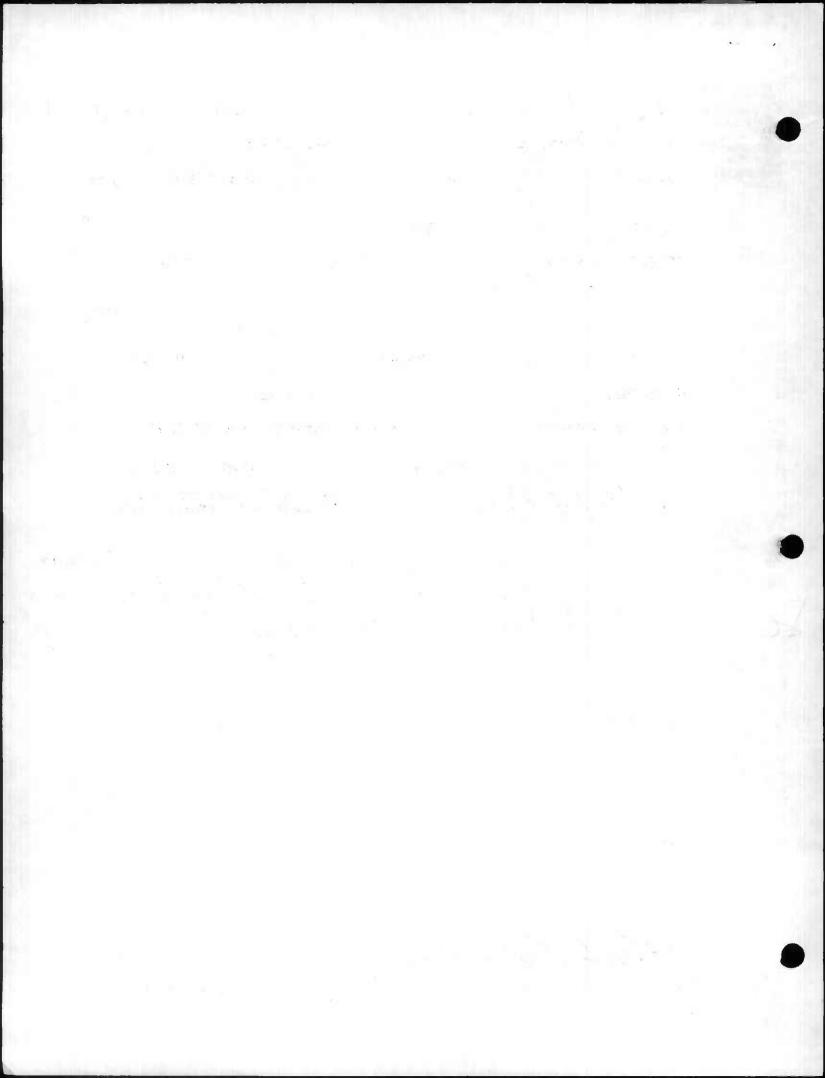
31. Date filed (Month, Day, Year)

32. Aegistrar's Signature

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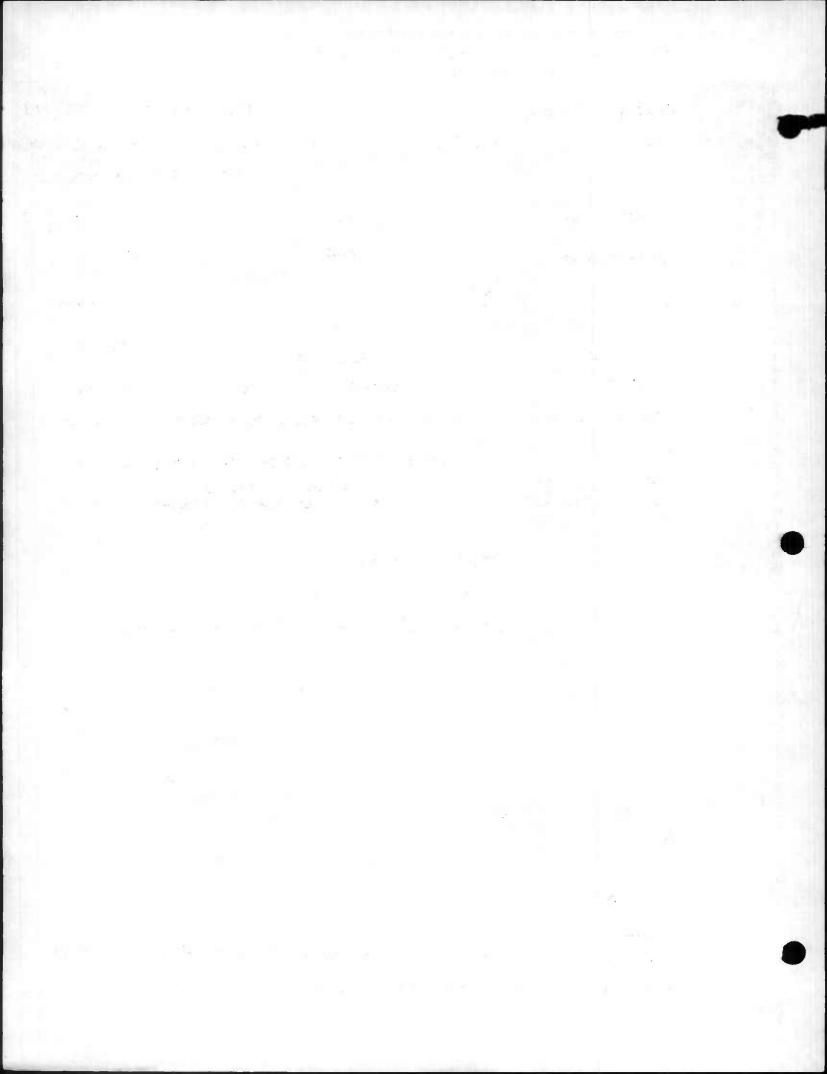
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State Registrar



State of Maryland / Department of Health and Mental Hygiene

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98-1144-510 ROBERT ROBINSON KAR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** OBERT KOBINSON 1998 MARCH 2:10P.M. 2, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner BALTIMORE MARYLAN LIBERY MEDICAL CENTER If Under 1 Yeer Months Days 8. Date of Birth (Month, Day, Yea SEP 5 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 100 M 2□ F Months Hours Yrs. Director Usual Residence of Decedent the Maryland 10e. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23a or 28a-f show treumstic event, the Modical Examiner must be notified at 1 Yes 2 No Funeral Director MARGLAND 10g. Citizen of What Country? et and Number 804 U,SA, 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "naturel", or Item any Injury or other treumatic event, the Mental Department of the Department of the Mental Department of 1 Never Married 2 Married 1 Yes 2 PNo Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION SECONDARY 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be ROSA ROBINSON KOBINSON KOBERT 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 804 RES

20b. Plece of Disposition (Name of cemetery, cremetory or other p ROBINSON ERVOIR ROSA 20a. Method of Disposition Date 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License E. GLOVER FUNERAL (giloul UNALO Approximete Interval Between Onset end Deeth 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Aquired immuno deficiency Syndrome Examiner Due to (or es a consequence of) Examiner ician end buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): requires that the daath certificata be axed physician Physician/Medical the Due to (or es a consequence of): 10 esn for Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Diabetes ρ 8 24b. Were autopsy findings available prior to 24a. Was en eutopsy performed? Completed peen completion of cause of death? certificata has INSPECTION 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1XXVes 2□ No 70 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this funerel 27. Manner of Death 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760. or Attending Physician: 24 hours after death. Hospital within 2 To the I To the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

O.C.M.E.

29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

1998 MARCH 3,

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

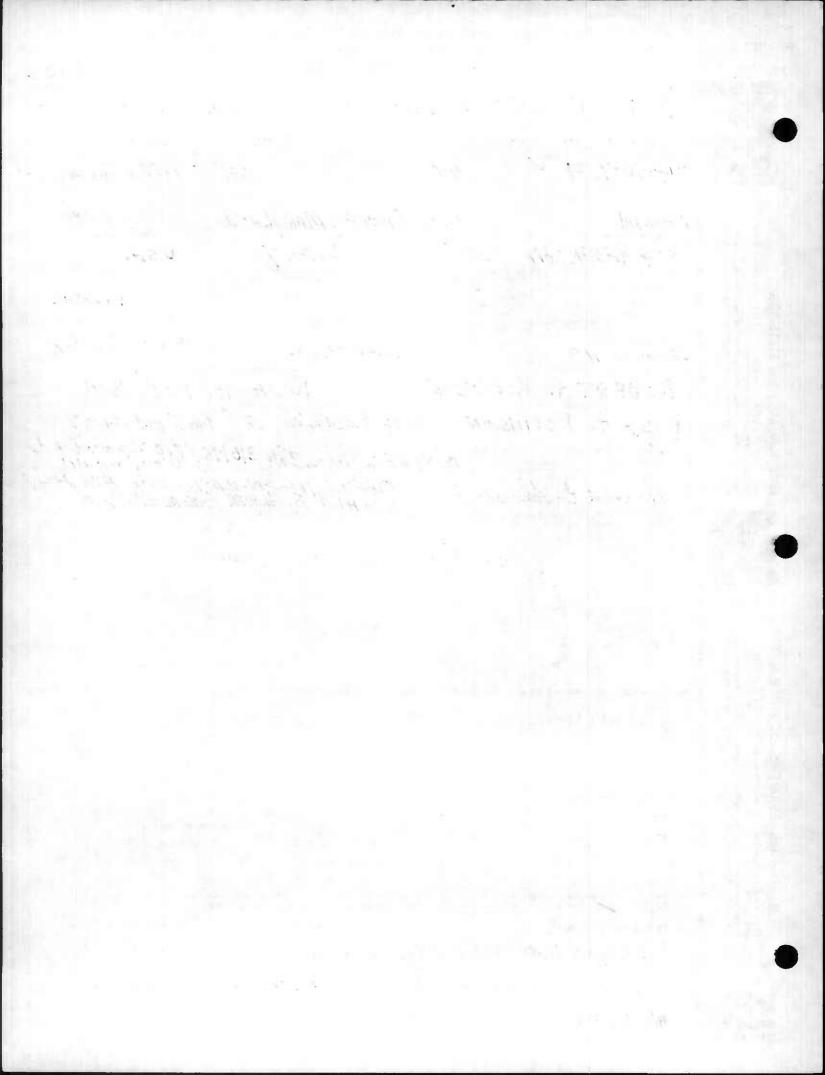
12 adent2, 111 Penn Street, Baltimore, Maryland 21201 phen 31. Date filed (Month, Day, Year)

State Registrar

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attending physicien for use es the buriel certificata be ex P.O. the 6 Division of Vital Records, peen page 2 cartificate has director. this uneral

JOHN TIMOYHY RAFFERTY Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month John Timothy Rafferty FEBRUARY 27, 1998 10:42 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ROUTE 40 AND STEVENSON ROAD Baltimore BALTIMORE If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer)
April 14, 1965 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1⊠ M 2□ F Yrs. Maryland 220-80-0057 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Baltimore County Perry Hall Directo ?? is marked other than "natural", or items 23a or 28a-f i traumatic evant, the Maxical Examiner must be norther 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 9418 Cross Road 21128 U.S.A. should be filed withIn 72 hours after death and Mental Hygiena. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritai Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: p White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry end Mental Hygiena. 12th Grade College (1-4or 5+) Roofer & Bricklayer Construction 18. Mother's Name (First, Middle, Malden Sumeme) 17. Fether's Name (First, Middle, Last) William **James** Rafferty Constance Gracki Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health end Important: If flam 27 is m any injury or other traum page. William James Rafferty/Father 9418 Cross Road, Perry Hall, Maryland 21128 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/3/98 Loudon Park Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licansee 22. Name and Address of Facility John C. Miller, Inc. Puanta C. Homo 6415 Belair Road, Baltimore, Euter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook of heert failure. List only one cause on each line. 6415 Belair Road, Baltimore, Maryland 21206 Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? 1 Yes 2 No Yes 2□ No 25. Was case referred to medical examiner?

1 Ayes 2 No 26. Plece of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) SCENE 10 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Injury or Attanding 1 Natural 5 Pending motor vehicle collision efter death. 1 Yes 2 No 2137 PM investigation 2127/98 2 Accident tha 28e. Placa of Injury - At home, farm, street, factory, offica

28f. Location (Street end Number or Rural Route Number,
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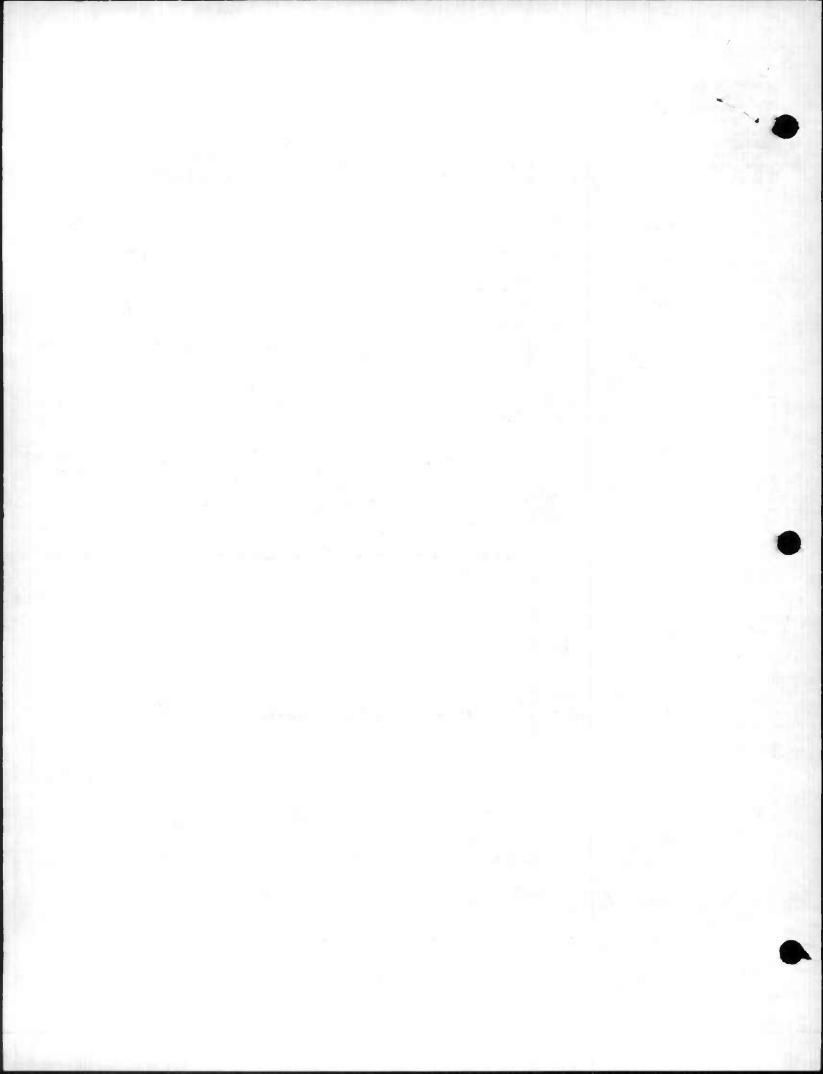
28f. Location (Street end Number)

28f. Location (Street end Number) yd ul bellil 4 Homlcide Hospital 24 hours 29a. Certifier edical completaly (Check only one) within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Chutero OCME. FEBRUARY 28, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Dennis huto.mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State windown Randell MAR 05 1998 Registrar

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State of Maryland / Department of Health and Mental Hygiene 0.0

		Decedent's Name (First, Middle, Last,)	Cer	tificate of	Death	2. Date of Dea			3. Time of Death
Physici /Modic		QUEENIE	Ste	ELE			Marci	Day 19	9 P	11:15
/Medic Examin		4a. Facility Name (If not Institution, give	street end number)	6		4b. City, Town, or L			of Deeth	
LAUIIII		CATON HMON				BAHANG				
Funeral		Sociel Security Number 6. Security Number	x , 7. Age (In yrs.	last birthday)	If Under 1 Yeer	If Under 24 Hrs.	8. Date of Birt	h	9. Birthole	ace (State or Foreign
Director		2/7-07-4689 1D Usual Residence of Decedent	IM 227 93	Yrs.	Months Days	Hours Min.	FEB . 2	3,1905 I		ace (Stete or Foreign ry) W C
with the Maryland e or 28a-f show	_	10a. State 10b. County	10c. City	y, Town or Loc					10	d. inside City Limits
88-f	cto	Maryon M/A		BALT	nun					1 Yes 2 No
F 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Oire	10e. Street and Number	P		10f. Zip Code			10g. Citizen of V	Vhet Count	ry?
23e	<u>a</u>	608 ROUNOUIEN	RURD		21	225		15	A	
5-0020 72 hours effer death natural; or frems 23	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes:		Vas Decedent of i Yes, specify Cub ☐ Yes 2 ☐ No	Hispanic Origin? (Sp ean, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Rac Bled Specify	e - America ek, White, e	
72 hours	ted	15. Decedent's Edu	cetion	16a. Deced	ent's Usual Occu	pation	in a	16b. Kind of Bu	siness/Indi	ustry
within sne.	Completed	(Specify only highest gred	College (1-4or 5+)	FACT	. /	pation during most of work id) UOPKEN	ing	Priva	t Sc	ISINESS
	ပိ	711 grade 17. Father's Name (First, Middle, Last)		INCF	7		o /Final Adiabata	Maldan Commun	-1	
ire, Maryland is a lend 2 should be flied if Health and Mentel Hygiem Z7 is marked other traumatic event,	To Be	RAY TA//18				18. Mother's Nam			e)	
lary		19e. Informant's Name/Relationship (Ty		19b. Meilin	g Address (Street	t end Number or Rur	al Route Numbe	er, City or Town,	Stete, Zip (Code) 21225
M alth 27 lb 27 lb r tra		DOVEATHA B.	Mayor	608	KILNO	VIEW RUI	OP BA	HHOTE	, MA	rylans
or Health		20a. Method of Disposition		lace of Dispos	sition (Name of		Date	20c. Location -		
0 = = 0		Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	LIEN	Con change	3	5-98	Kalley	116 1	Narylons
Baltimo		21. Signature of Funeral Service License		22.	Name and Addre	es of Fecility Ch	ATMA	W - NA	2015	F.H.
Ball permi lmpol lmpol eny fr		> Stray of	ani	33	YU REI	STEXSTOW,	N ROM	P		
		23a. Part1. Ent lhe disea , or complishock, or heart failure. List only or	cations that caused the death	n. Do not ente	or the mode of dyl	ng, such as cardiac	or respiretory er	3/2/1		Approximete Intervel Between
Physician /Medicai		Immediate Cause (Final disease or condition resulting in death)	/ www G	estro he	1	Polees				Onset and Deeth
Examiner	e	resulting in death)	Due to (a	r 85 8 sonsequ						
outed d	Examiner	Sequentially liet conditions	Due to (or	r es a consequ	ience of):				i	
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	edical	that initieted events resulting In death) Last	Due to (or	r as a consequ	ence of):					
c 66	Med								1	
Box ath cert attendin for use	an		l						1	
O dea	SC	Part II. Other eignificant conditions con	tributing to death but not resu	ulting in the un	derlying ceuse gi	ven in Pert I.	23b. Dld t	obacco use cor	ntribute to	the cause of death?
P.O	Physician/M	Min July lus	Deso. 30. 5	- 1	102.00	Mellity	10	Yes 20 No	3 Prob	ably 4 Unknown
S th	þ	/ U U I / U COUCH	o jacobano		- Courter	receiving				
I Records, P.O. Box 687 The law requires that the death certificate are hes been signed by the attending physpage 2 should be detached for use as the	Completed						24a. Was	an autopsy	evei	re autopsy findings ilable prior to
Baw r	ple								of de	eath?
Vital Rec	PO.						1 🗆 Y	es 2000	10	Yes 2□ No
	Be	25. Was case referred to medical				26. Place of Deat	h (Check only o	ne)		
f Vita	To	examiner?	ospital:	ER/Outpatient	3 DOA Oti			lence 6 🗆 Oth	er (Specify))
Vision of Vita Attending Physician: or death. ector: After this certific by the funeral director,		27. Menner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of	28c. Inju Wo	ry at		ow Injury occur		
ior ath. Aft. e fur e fur	atio	1 Netural 5 ☐ Pending 2 Accident Investigation	(Month, Day Year)	Injury		Yes 2 □ No				
Division or Attending latter death. Director: After d in by the fune	2	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, stre	et, factory, office		28f. Location (S	Street end Numb	er or Rurel	Route Number,
d afte	Certification:	4 Homicide	building, etc. (Specify	")			City or Tou	rri, 3(8(8)		
Division of To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director. After this completely filled in by the funeral d		29a. Certifier 1 Certifying Phys	iclan: To the best of my knowner: On the basis of examinat	wledge, death	occurred at the ti	me, date and place,	and due to the	ceuse(s) and ma	nner as sta	ited.
the H in 24 he Fl	Medical	0.107	end manner stated.	ion and/or inve	estigation, in my (pinion, death occur	ed et the time,	uate and place, a	and due to t	ne cause(s)
To t com	2	29b. Signature and title of certifier	. A	·	29c. Licens	-		29d. Date signer		ey, Yeer)
12		b Culymae M7 A	dendy Doc	CN	Da	1684		3.4	98	
4		30. Name and eddress of person who co	mpleted cause of death (Item	23a) (Type, F	Print)	1.20				
1	-	30. Name and eddress of person who co	-109 RITE	HIR 10	WY, PA	SHOENH	, 170 .	11122	•	
Sta	te	31. Dete filed (Month, Day, Year)	Hegiarrar's Signat	turo						



State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death FEB. 28, 1998 1:30am W. SOMMERS 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE 3803 BRENTFORD ROAD RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month Day Year)
JAN 27,1915
MARYLAND 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min 1₽ M 2□ F 83 Yrs. 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No BALTIMORE RANDALLSTOWN 10f. Zip Code 10g. Citizen of What Country? 21133 USA 3803 BRENTFORD ROAD 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14 Race - American Indian Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Merried 2 Married

1 ☐ Yes 2 No Specify:

(Give kind of work done during most of working life. DO NOT use retired)

BETH EL MEMORIAL PARK

22. Name and Address of Facility

CAB DRIVER

Sol Levinson & Bros., Inc.

18. Mother's Name (First, Middle, Maiden Surname)

8900 Reisterstown Road Pikesville, MD 21208

19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3803 BRENTFORD ROAD RANDALLSTOWN, MD 21133

TILLIE

16a. Decedent's Usual Occupation

SOMMERS

20b. Place of Disposition (Neme of cemetery crematory or other)

Due to (or as a consequence of)

Prostate

Funeral Director

Physician

/Medical

Examiner

ABRAHAM

10b. County

College (1-4or 5+)

Metastatic

5. Social Security Number

217-03-0057

10a State

MARYLAND

10e. Street and Number

Usual Residence of Decedent

3 ☐ Widowed 4 ☐ Divorced

28a-f show ? is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Modical Examinat must be notified as Directo Funeral þ

death with the Marylend filed within 72 hours after of Hygiene. ther than "natural", or iter permit. Pages 1 and 2 should be f Department of Health and Mental I Important: if item 27 is marked of any injury or other traumatic eve any in

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Records, P.O. Box 68760. physician The law requires that the death certificate be the ! for use es 50 signed by the e been si page 2 has certificate Division of Vital Physician: this

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Completed

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Certification:

edical

funeral After or Attending death. Director: A aftar • Funeral Dire letaly filled in b Hospital pletaly within 2

10-41

State Registrar

Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) CHARLES 19e. Informant's Name/Relationship (Type, Print) MRS. HELEN SOMMERS (WIFE) 20e. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as e consequença of) Due to (or as a consequence of): Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 24a. Was an autopsy 1 Yes 2 No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 20 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? 1 Naturel 5 ☐ Pending 1 TYes 2 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifie (Check only one)

Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) and manner es stated. 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

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Specify: WHITE

20c. Location - City or Town, State

3-2+1998 RANDALLSTOWN, MD

TRANSPORTATION

CULP

Approximate Interval Between Onset and Death

3 Probably 4 Unknown

24b. Were autopsy findings evailable prior to

completion of ceuse of death?

1 TYes 2 □ No

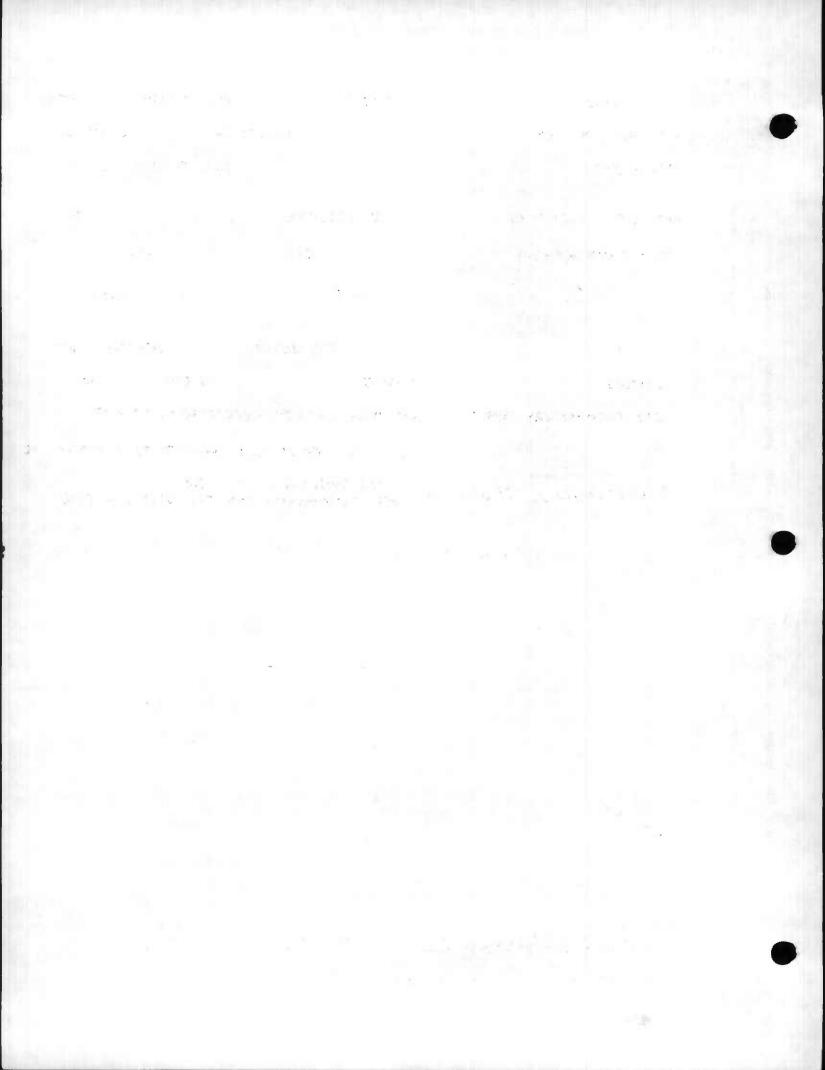
Years

16b. Kind of Business/Industry

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Bld Sk Cesad Court 306 4000

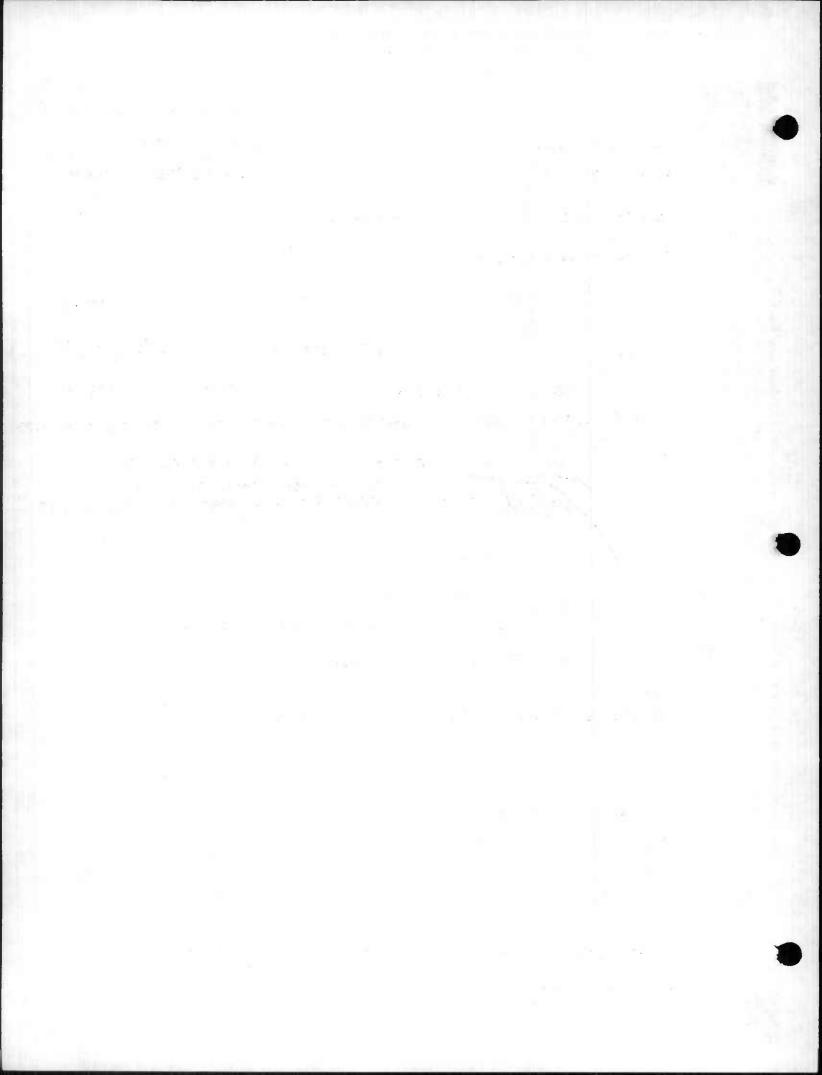
Boltmore MD 21208

31. Dete filed (Month, Day, Year) 22. Registrar's Signature Waydson-Randson MAR 05 1998



State of Maryland / Department of Health and Mental Hygiene

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Physici /Medic		BEN		SLOAN			MARCH			0843	
Examir		4a. Facility Neme (If not institution, g	giva street and number)			4b. City, Town, or	Location of Death		-		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death STERN Month 4e. Fecility Nema (If not institution, give street end number) 2 600 Costy Horget 50 4b. City, Town, or Location of Daath 4c. County of Death Liberty Medical Center BALTIMORE, MD BALTIMORE 21215 N/A 5. Social Security Number 7. Aga (In yrs. last birthday) 88 Yrs. If Undar 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6. Sax 9. Birthplaca (Stata or Foreign 220-36-2831 1□ M 25 F Days MARYLAND Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No MARYLAND N/A BALTIMORE 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 2910-C TERRY DRIVE 21209 USA 12. Wes Decedant Evar In U,S. Armed Forces? 1 ☐ Yas ▲ No Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Bleck, Whita, atc. 1 Never Merried 2 Married 1 ☐ Yas 2 ZNo Specify: If Yas, Giva Yaar or Datas: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grada completed) Elamentary/Secondery (0-12) Collaga (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maldan Surnama) SHUMAN HYMAN SARAH 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) MR. MILTON STERN (HUSBAND) 2910-C TERRY DRIVE BALTIMORE, MD 21209 20b. Place of Disposition (Nama of cemetery, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Buriel 2 ☐ Cremation 3 ☐ Ramoval from Stata 3-3-1998 HEBREW YOUNG MENS BALTIMORE, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name and Addrass of Fecility Sol Levinson & Bros., Inc. 21. Signature of Funaral Sarvice Licenaas 8900 Reisterstown Road Pikesville, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Between Onset end Death DNEUMONIA. Left lower Lobe Immadiata Cause (Final disease or condition rasulting in death) Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contributs to the cause of death? 1 Y88 2 No 3 Probably 4 Unknown pertengion. Cerelesovascular 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy 1 ☐ Yas 2 Ø No 1 ☐ Yes 2 No 26. Placa of Death (Check only ona) Hospitai: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred

attending physician and for use as the burial-transit Records, P.O. Box 68760. signed by t Division of Vital

Physician/Medical Completed Certification:

To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this cardifica completely lilled in by the funeral director, t

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

the Marylend

pernit. Pagas 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Haalth end Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic avent, the Medical Examinar must be notified at

Physician

/Medical

Examiner

Baitimore, Maryland 21215-0020

edical

Registrar

25. Was cesa rafarred to medical exeminar? 1 ☐ Yas 2 ☑ No 28a. Deta of Injury (Month, Day Year) 27. Mannar of Death 1 Netural 2 Accident 5 Panding invastigation 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 29a. Cartifian

1 Yas 2 No Location (Street end Number or Rural Routa Number, City or Town, Stata)

Miles Cartifying Physician: To the best of my knowledga, death occurred at the time, dete end piece, end due to the causa(s) and mannar as stated.

Imaginary Cartifying Physician: To the best of my knowledga, death occurred at the time, data and place, and due to the cause(s) and manner steted. 29d. Data signed (Month, Day, Year) 29b. Signature end titla of certifiar 29c. Licanse number

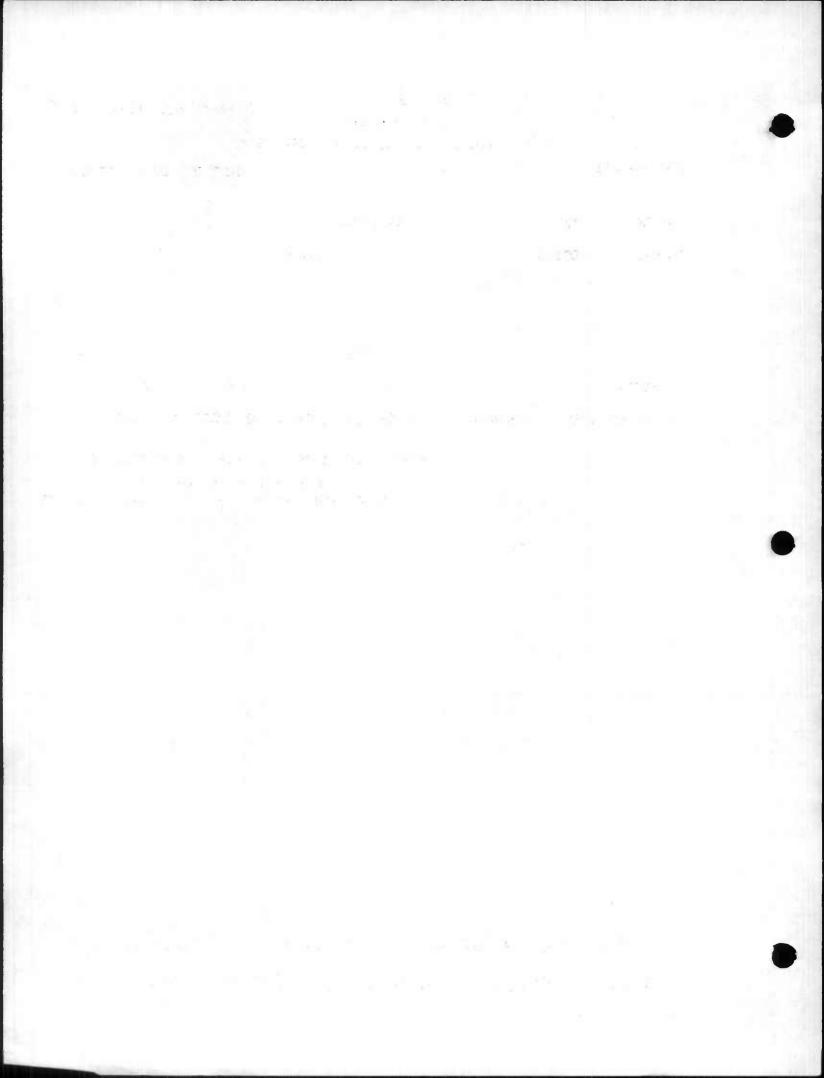
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30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)
[KWANG, N. Kim, Mb. 2600 besty Height. BALTimore. Mb. 21213

31. Data filed (Month, Day, Year) MAR 05 1998

July 32 Pegistrar's Signature

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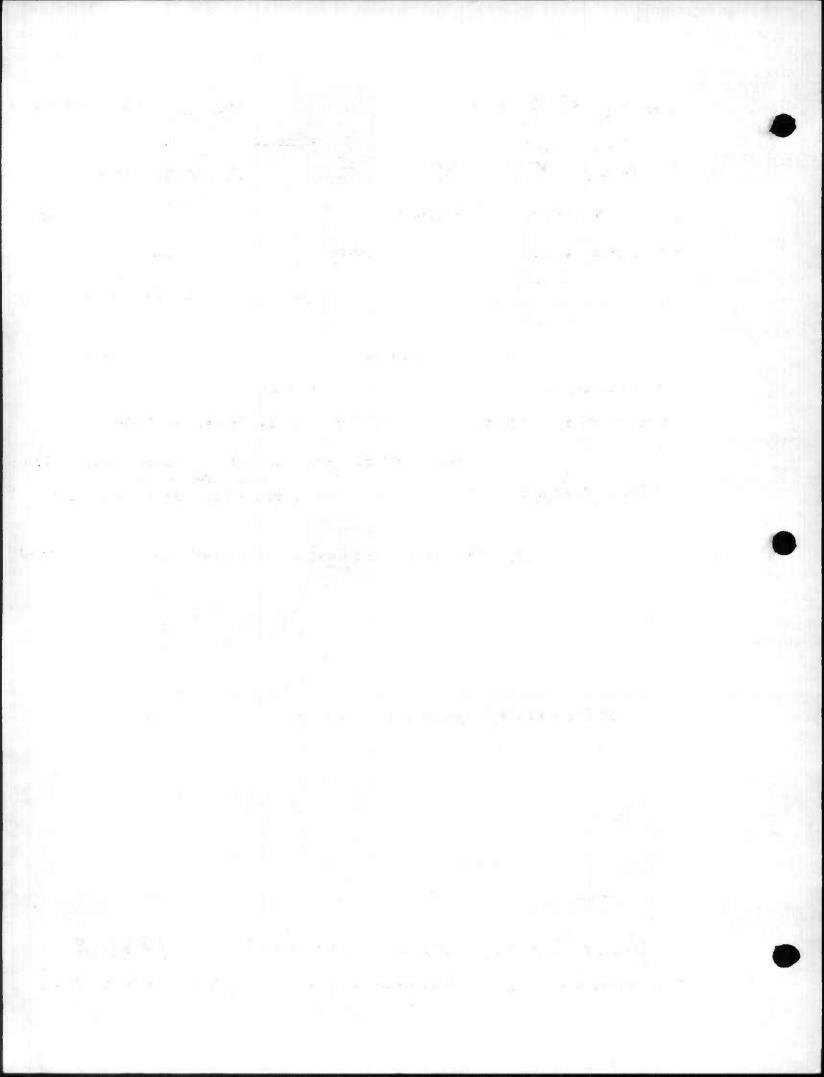


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 20 /Medical 4e. Facility Name (If hot Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner tranklin Baltimore Baltimore Woods 7. Age (In yrs. lest birthday).
88 Yrs. If Under 1 Yeer If Under 24 Hrs. Sociel Security Number 6. Sex Birthplaca (Stete or Foreign Country) **Funeral** 1 M 2□ F Days Hours 522-44-651 Director Tennessee Usual Residence of Decedeni the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inaide City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Maxical Examiner must be notified at PA Montgomery Erdenheim 1 Tyes 2000 Director 10e. Street and Numbar 10f. Zip Code 10g. Citizen of Whet Country? With **#5 Montgomery Avenue** 19038 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or then eny injury or other traumetic event, the Medical Exemper 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Merrled Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Attorney U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Clarence D. Snyder Edna Keyes 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Cameron C. Snyder / Cousin 5163 Terrace Dr., Baltimore, MD 21236 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burief 2 ☐ Cremation 3 ☐ Removei from State 4 ☐ Donation 5 ☐ Other (Specify) Geo. Washington Mem. Pk. 3/2/98 Plymouth Mtg., PA 19462 21. Signatura of Funeral Service 22. Name and Address of Facility McClure Funeral Home, Inc. Stenton Ave. & Butler Pike, Plymouth Mtg., PA 23a. Part1. Enter the disease, or copplications thei caused the death. Do not enter the mode of dying, auch as cardiec or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final METASTATIC SQUAMOUS CELL SKIN CANCER UNKHOWN disease or condition resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequenca of): physician a P.O. Box 6876d 18 Physician/Medical Due to (or es e consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA, HYPOTHYROLD Records. à 24b. Were autopsy findings available prior to completion of cause of death? should t Completed 24a. Was an autopsy performed? certificate has 204 No 1 ☐ Yes 2 No 1 Yes Division of Vital Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 Matural To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. Medical 29e. Certifier 29b. Signatura end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D4000 8 ans 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) PARSHALL FRANKLIN SQUARE DR. , BALTIMORE 9105 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature State MAR 05 1998 the Davidson-Randsee

DHMH 16 Ray 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3, Dey 1998eer MARCH 7:10AM LAWRENCE FRANK STERN 4a Facility Neme (If not institution, give street end number) 704 SOUTH DEAN STREET 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. 0 CT 25, 1937 5. Social Security Number 217-34-4101 6. Sex 1 M M 2 ☐ F 7. Age (In yrs. last birthdey) 60 Yrs. 9. Birthplace (State or Foreign Months Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits CITY BALTIMORE CITY MD 1 Yes 2 No 10f. Zip Code 21224 10e. Street end Number 704 SOUTH DEAN 10g. Citizen of Whet Country? STREET 12. Was Decedent Ever In U,S. Armed Forces?, 1 ☐ Yes 27 DNo if Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) IRON WORKER IRON 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) VIOLET HARMIS LAWRENCE T. STERN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 704 SOUTH DEAN STREET BALTIMORE, MD 21224 JOYCE STERN/WIFE 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 1 □ Burial 2 1 □ Cremation 3 □ Removel from State 20c. Location - City or Town, Stete GREEN MOUNT CEMETERY 3/4/98 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility LILLY & ZEILER, INC 1901 EASTERN AVENUE raleth BALTIMORE, MD 21231 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in deeth) Gastric Carcindno 2 months Due to (or es e consequence of) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Anterioscleratic Cordinuscular Distase 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Tes 2 XN0 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No 28e. Dete of injury (Month, Dey Year) 27. Menner of Deeth

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-4 show say injury or other traumatic event, the Medical Evandre frame by notified anones.

altimore, Maryland 21215-0020

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pege 2 s certificate hes this funeral After

à Completed Be 2

2 Accident

3 ☐ Sulcide

29e. Certifier

4 Homicide

(Check only one)

29b. Signature end title of certifier

Certification:

edical

Physician/Medical Examiner

or Attending s efter death. filled in by Hospital 24 hours To the Hosp within 24 hor To the Fune completely fi

Division of Vital Records.

State Registrar

Attending

28b. Time of

28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. 29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

Morren

1 TYes 2 □ No

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

5 Pending investigation

6 Could not be determined

5. 301 - St. Paul Place Baltindre, Md. MARVIN FECDMAN MID 31. Dete filed (Month, Dey, Year) MAR 05 32 Albuniars Statute Grandell

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

ent out of a such and a model to the first that the executivation of the security

3. Tima of Death

Physician /Medical **Examiner**

February 16 1998 Lillie M. nonpson 6 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Mercy Medical Center Baltimore Baltimore City 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year)
July 19, 1913

8. Birthplaca (Stata or Foraign Country)
Maryland **Funeral** 1 M 2 F Months Days Hours Min 212-22-9401 84 Yrs. Director Usual Rasidance of Dacedant with the Maryland 10a. Stata 10b. County r than "natural", or items 23e or 28e-f show the Medical Exampler must be notified at 10c. City, Town or Location 10d. insida City Limits **Funeral Director** 1 X Yas 2 No Maryland Baltimore City Baltimore 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? U.S.A. 124 W. Franklin Street 21201 death v 12. Was Decedant Evar in U.S. Armed Forcas?unknown 1 ☐ Yas 2 ☐ No If Yas, Giva 11. Marital Status Was Dacedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amaricen Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after not of Health and Mentel Hygiene.
Int: If Item 27 is marked other than "natural, or flee ury or other traumatic event, I'm Medical Express.
Inty or other traumatic event, I'm Medical Express. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yas 2 ☐ No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Be Completed 15. Dacedant's Education (Specify only highest grade completed) 16a. Decedant's Usuai Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) unknown unknown Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Benjamin Emory Margaret Sampson Gunther 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1109 N. Augusta Avenue, Baltimore, Maryland 21229 Margaret Booker/daughter 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata permit. Pege Department Important: If any injury or 4 ☑ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Lordina Ronald S. Wade ²² Name and Addrass of Facility Board, 655 W. Baltimore Street Director nie trenan Baltimore, Maryland 21201

23a. Parti. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21201 Approximata Interval Batween Onsat and Daath **Physician** Immadiata Causa (Final disaasa or condition rasulting in daath) /Medicai **Examiner** Examine PNEUMONIA Attending Physician: The law requires that the deeth certificate be executed Sequantially list conditions, if any, laading to immadiata ceusa. Enter Underlying Cause (Disease or injury that initiated avants rasulting in death) Last use as the buriel-tran Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of): d for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by Congestive heart 1 Yee 2 No 3 Probably 4 Unknown þ page 2 should be Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy complation of causa has of death? Coronary certificate 1 Tas 1 ☐ Yas 2 ☐ No 25. Was cesa rafarred to medical axaminar? Be 28. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA nours after deeth.

neral Director: After this of y filled in by the funeral dire Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 27. Mannar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 T Homicida To the Hospital o within 24 hours af To the Funeral Di completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifian (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) February 16, 1998 30. Nama and address of parson who completed cause of death (Itam 23a) (Type, Print)
NEVINS W Todd 301 St Paul Place BAltimure

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32. Registrar's Signatura

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Year)

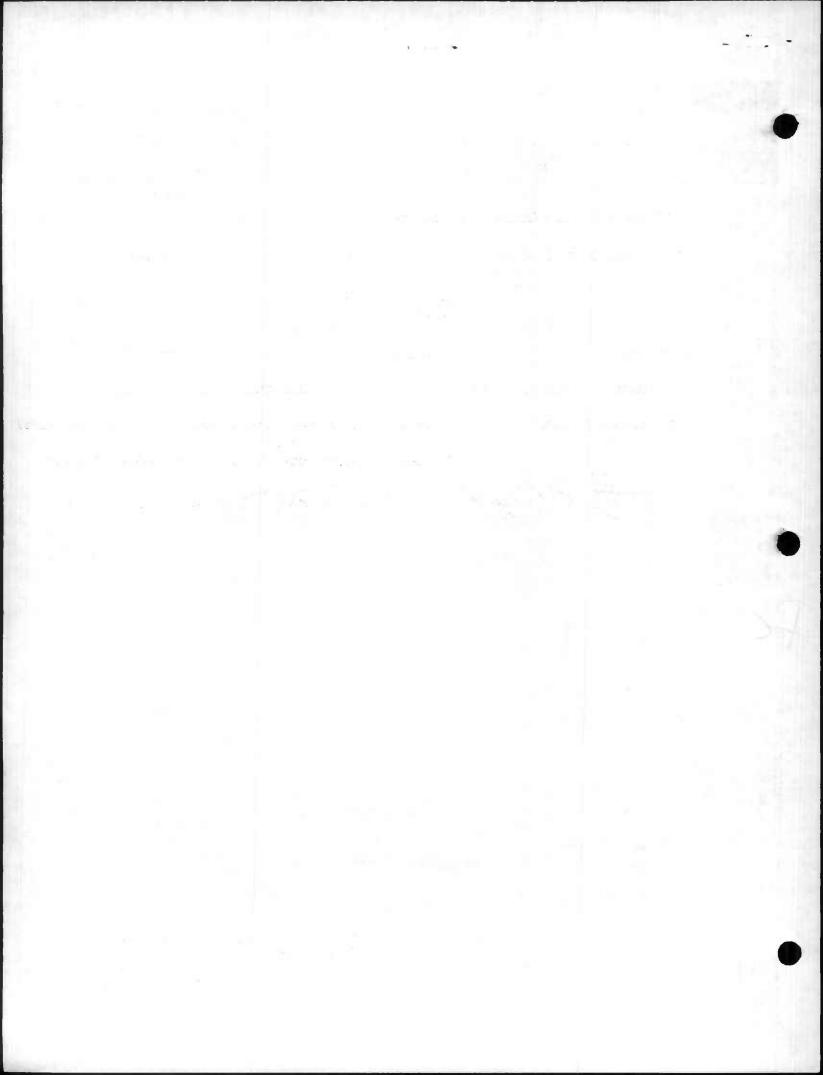
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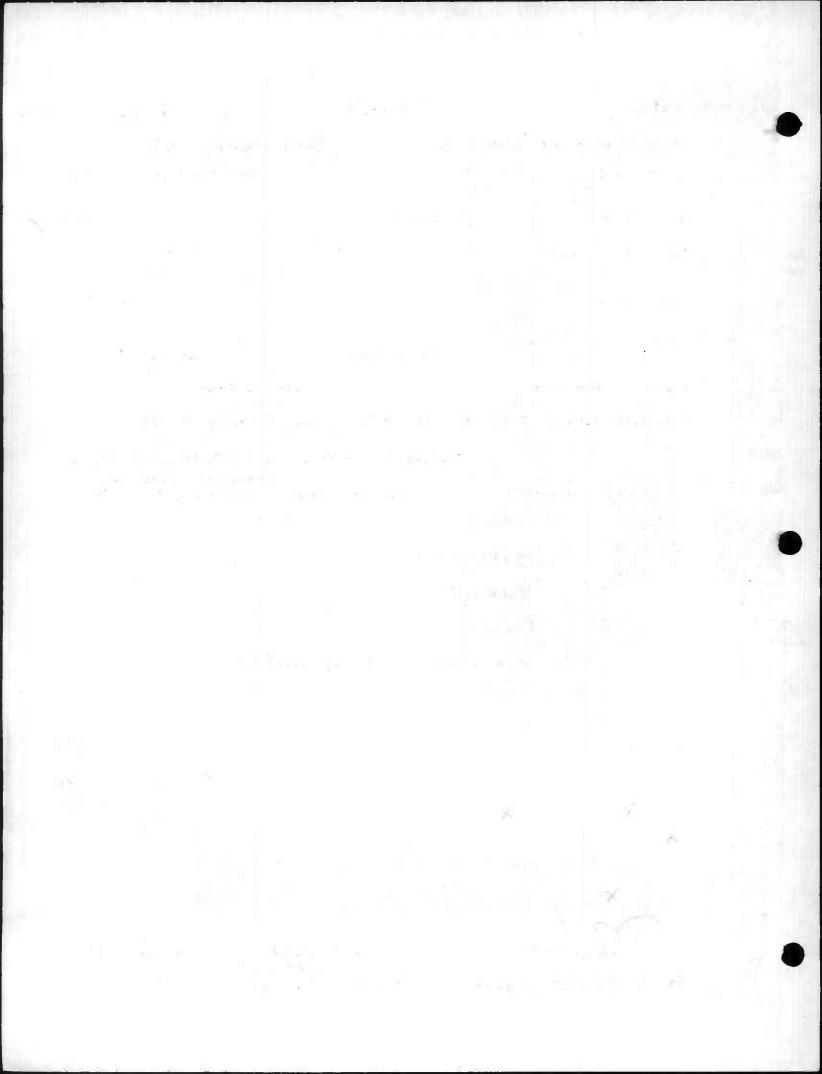
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פַ	d out	Be C	17. Father's Name (First, A	fiddle, Last)		-,					18. Mother's Nar	ne (First, Middle	, Maldan Suman	ne)			
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P	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													Approximate Interval Between Onset and Death		
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Division	otor otor	fica	3 ☐ Suicide 6 ☐	Could not ba		ce of Injury	- At home,	farm, stre				28f. Location	Street end Numb	er or Rura	al Route Number.		
á.	its for Attending Physics after death. In Director: After this fied in by the funeral d	erti	4 Homicide	atemmed	build	ding, etc. (Specify)		.,,	,			wn, State)				
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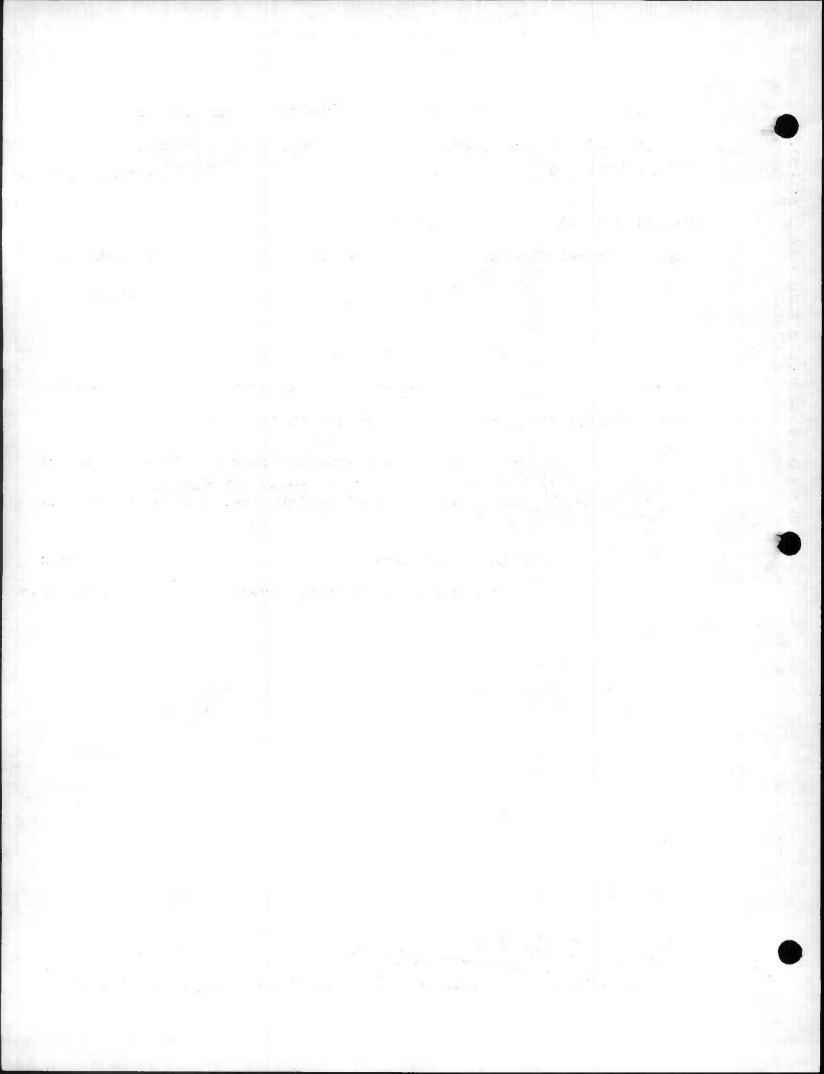
State of Maryland / Department of Health and Mental Hygiene

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eral		5. Social Security Number	6. Sex	7. Age (In yrs	lest birthday)	if Under 1 Year Months Day		24 Hrs. Min.	8. Date of i	Birth Pour Voor	9. Birthpi	ace (State or Foreig
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1 9	2	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Count	try?
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ov Funeral Director	by runer	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorce	Armed Formed 1 Yes	2 A No ive	t	Vas Decedent of Yes, specify Cu			ecify Yes or I Rican, etc.)	No- 14. Ra Bla Speci	ice - America ack, White, e	etc.
7	2	15. Deceder	nt's Educetion		16a. Decad	ent's Usuel Occi	upation			16b. Kind of 8	Business/Ind	lustry
Completed	10	(Specify only higher Elementary/Secondary (0-12)	est grede completed)	1-4or 5+)	(Give	kind of work don OO NOT use retir	e during mos	st of worki	ng			
200	5	12			Sales	Clerk				Retail	Sales	μ
8	0	17. Father's Name (First, Middle,								le, Maiden Sume		
٢	2		es Handschiegel Antonette Tre ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Nu									
		19a. tnformant's Name/Relation: Elizabeth Ritcl		phter		g Address (Stree Selford					n, Stete, Zip (2.27	Code)
		20a. Method of Disposition	inte / Daug	20b.	Placa of Dispos	sition (Neme of		Dult	Dete	20c. Location		en State
		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State		Forest	,	'em		Owings		
à	-	21. Signature of Funeral Service		Oa.						rk Fune:		
DUCE		13- QC	him							nore, MD	2122	
	+	23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that of	caused the dea								Approximate
cian/Medicai Examiner		Sequentially list conditions, if any, teading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	Per . Rec	rcyto Due to (Pres a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequen	lence of):	20 m	atoi	Qio			
Physician/Me												
hysi		Part il. Other significant condition	ona contributing to de	eath but not res	ulting In the un	derlying cause g	given in Part i	i.	23b. Did tobacco use contribute to the cause of dea			
by Pl									10	Yes 2□No	3 Prob	abiy 45 Unknow
Completed b										s an autopsy formed?	evai	re autopsy findings ilable prior to apletion of cause eeth?
Con									1)×	Yes 2□No	10	Yes 2 No
Be		25. Was case referred to medica exeminer?					26. Place	of Death	(Check only	one)		
5	-	1 ☐ Yes 2 No			ER/Outpatient	3LI DOA		ursing Hon	ne 5 Re	sidence 6 Oti	her (Specify))
lon		27. Menner of Death 1 Natural 5 ☐ Pendir	'3'	of Injury th, Dey Year)	28b. Time of tnjury	28c. Inju			28d. Describe	how injury occu	rred	
Certification:		2 Accident investignment inve	not be	of Injuny - At h	ome form stre	M 1 [Yes 2		of Location	(Street and Num.	har or Puml	Pouto Number
ent		4 ☐ Homicide determ	buildi	ng, etc. (Specif	y)	er, ractory, office		-	City or T	own, Stete)	Der Or Fluier	riodio radiiber,
edical C		29a. Certifier (Check only one) Certifyin	ng Phyatctan: To the Examiner: On the ba	best of my kno asis of examina ner stated.	wledge, death tion and/or inve	occurred et the t estigation, in my	time, date an opinion, dea	d place, a th occurre	and due to the	e ceuse(s) and m	anner es sta and due to t	ited. the ceuse(s)
Σ		29b. Signature and tria of pertition	1			29c. Licen	nse number			29d. Dete signe		
		1 Dan	mo			DL	175	18		2-2	27-6	78
	3	Name and address of person	who completed caus	of death (Iten	n 23a) (Type, F	There	sa Buc	k, M	.D.	0.001		
	_	J. Olde	0c 21h	er -	· L	altin	2014	1	D	21201		
State	3	31. Date filed (Month, Dey, Year)	- 1.0	Davidson	iture			1				
istrar		MAR 0 5 1998	D June	miniation.	-Nouthern							



State of Maryland / Department of Health and Mental Hygiene 98 06976

					Cei	rtificate of	Death		Reg. No.			
Physici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of D	eeth Dev	Yeer	3. Time of Deeth	
/Medic		Frank		Franci	cis Thompson			March			09:55AM	
Examir		4e. Fecility Neme (If not institution,	give street end n	um <i>ber)</i>			4b. City, Town, or I		th 4c. County		03.33M1	
		VA Maryland Hea	th Care	System			Perry Po	nint	Ceci	1		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. le		If Under 1 Year Months Days		8. Dete of B	irth		place (Stete or Foreign	
Director		187-16-9714	X □ M 2□ F	72	Yrs.	Months Days	Hours Will.	May 1	1 1925	Pen	nsylvania	
P .		Usuel Residence of Decadant										
show date	_	10e. Stete 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits	
e Me	cto	Maryland Ceci	1	E	Lkton						1 ☐ Yes 2 ☐ No	
\$ 50 E	Directo	10e. Street end Number	10e. Street end Number 10f. Zip Code 10g. Citizar								ntry?	
23°		100 S. Laure	l Stree	t.		2192	21		U.S. o	f Am	erica	
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene 23e or 28a-f show ther then hearing Examiner must be notified at	Funeral	11. Maritel Stetus	12. Was Dec	cedent Ever in U,S		Was Decedent of	Hispenic Orlgin? (S ben, Mexican, Puert	pecify Yes or N	lo- 14. Rad	a - Americ		
or it		1 Never Married 2 ☐ Marrie	d 1-12 Yes If Yes, G	2 No -		1 □ Yes \$₹□ No		o moan, etc.,		ck, Whita,		
- M	by	3 ☐ Widowed 4 ☐ Divorced	Yeer or I		15	10 100 20 100	эреспу.		Specin	Whi	te	
iane. than enaturel', tre Medical Ex	Completed	15. Decedent's (Specify only highest	Education		16a. Deced	dent's Usuel Occu	petion during most of wor	kina	16b. Kind of B	usiness/In	dustry	
Man.	ple	Elementery/Secondary (0-12)		(1-4or 5+)	lifa. I	DO NOT use retire	ed)	King				
ther tha	Son	8	N		D	ISABLED)			NA		
- 0 5	To Be C	17. Fether's Nama (First, Middle, L	ast)				18. Mother's Nan	ne (First, Middle	e, Maidan Suman	ne)		
marked o		Frank			Tho	mpson	Marga	ret			Bell	
and le		19a. Informant's Neme/Reletionsh	ip (Type, Print)		19b. Meilir	ng Addrass (Straa	t and Number or Ru	ral Routa Num	ber, City or Town,	Stete, Zip	Coda)	
€2.E		Emma Kissell	(Siste	r)	154	More St	. Phila	delphi	la,Pa.	1914	8	
		20e. Method of Disposition		20b. Pla	aca of Dispo	sition (Name of netory or other ple		Dete	20c. Location -			
Department of important: If It any injury or once.		Burial 2 Cremetion :		State					D		lle, Pa.	
deen cermicate be secured a attending physician end ed for use as the buriel-transit	lan/Medical Examiner	Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants rasulting in daeth) Lest	b. Chro	Dua to (or	es a consequence es e c	ve Pulmo	onary Dise	ease		t	wenty year	
deteched for	Physician	Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tob.							d tobacco use co	obacco use contribute to the cause of death?		
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been sig should b									s en autopsy		are eutopsy findings eileble prior to	
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cartificeta rector, pag		25. Wes case referred to medical								11	Yes 2 No	
	o Be	exeminer?	Hospital:			Ot	26. Placa of Dee					
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Direct In by	art.	4 ☐ HomicIda datarmir	build	e of Injury - At hor ling, etc. (Specify)	na, iami, str	eat, factory, office		City or To	own, Stete)	er or mure	ir Addie Ivariber,	
filled in	Ö	29a. Cartifiar 1X Certifying	Dhysteian, To the	host of my know	1							
Funeral lately filled	edical	(Check only one)	xaminer : On the b	easis of examination	on end/or inv	astigation, in my	ima, data and piace opinion, deeth occu	, and due to the rred at tha tima	a ceusa(s) and ma , data and placa,	annar as s end due to	the cause(s)	
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1		9			NA.C	D420	14		March 04	1, 19	98	
	- 1	30. Nama end eddrass of parson w	ho completed oeu	se of daeth (Item	23a) (Type,	Print)						
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Sta		SURINDERPAL SODE 31. Date filed (Month, Day, Year)	I, M.D.,	VA Mary Registers Signature	***		are Syste	m, Perr	y Point,	MD	21902	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Dey Martin Weise March 1998 9:00 PM /Medical 4a. Fecility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 206 Northmoor Dr. Silver Spring Montgomery 6. Sex 1 ☑ M 2 ☐ F If Undar 1 Year If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Pay, Year) Dec. 14, 1917 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Deys Months Indiana Yrs 80 Dec. 307-30-3032 Usuel Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Montgomery Silver Spring 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 20907 USA 206 Northmoor Dr. Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 [AYes 2 □ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Mexican, Puarto Rican, etc.) 11 Marital Status 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: by 3XXWidowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Agriculture Farmer 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Weise Pontow Albert Laura 2 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 206 Northmoor Dr. Silver Spring, Md. 20907 Andrea Pauli (Daughter) 20b. Plece of Disposition (Neme of cematary, crematory or other plece) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Crametion 3 ☐ Removel from Stata 20c. Location - City or Town, Stete 3/6/98 St. Paul Cemetery Kouts, Indiana 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility
Stallings Funeral Home PA 21. Signature of Funeral Service Licensee 3111 Mountain Rd. Pasadena, Md. 21122 ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory errast, each line. 23a. Part1. Enter the disease, or compleshock, or heart feilure. List only of Approximeta intervel Between Onset end Deeth Immediete Cause (Finel disease or condition resulting in deeth) Respiratory Failure 12 Hours Dua to (or es a consequence of) Metastatic Disease 4 Months Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es e consequance of): Small Cell Adenocarcinoma of Lung 6 Months thet initieted events resulting In deeth) Lest Dua to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Nos 2 No 3 Probably 4 Unknown Arthritis 24b. Were eutopsy findings aveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to-medical 28. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 28c. Injury et Work? 27. Menger of Deeth 28b. Tima of 28d. Describe how Injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Health end Mentel Hyglane. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examines mans once.

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

with the Maryland

Physician/Medical Examiner þ Completed Be

The law requiras that the death certificate be executed ig physician and es the buriel-transit Box 68760. attending USB P.O. | ed by the a signed by page certificata Physician: Certification: To After this

Division of Vital Records, A Hospital or Attending Pl n 2. Nour affel death. The Fureral Director: After include the funer To the Within 2 To the Complet

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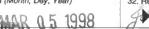
DELANTY, M.D. 9801 GCORGIA RICHARD P. 31. Dete filed (Month, Dey, Year)

29b. Signetura end title of certified

2 Accident 3 Sulcide

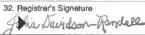
4 Homicide

29a. Certifier



30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

6 Could not be determined



28e. Pleca of Injury - At home, farm, straet, fectory, office building, etc. (Specify)

1 Certifying Phyelcien: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) and menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) end manner stated.

29c. License number

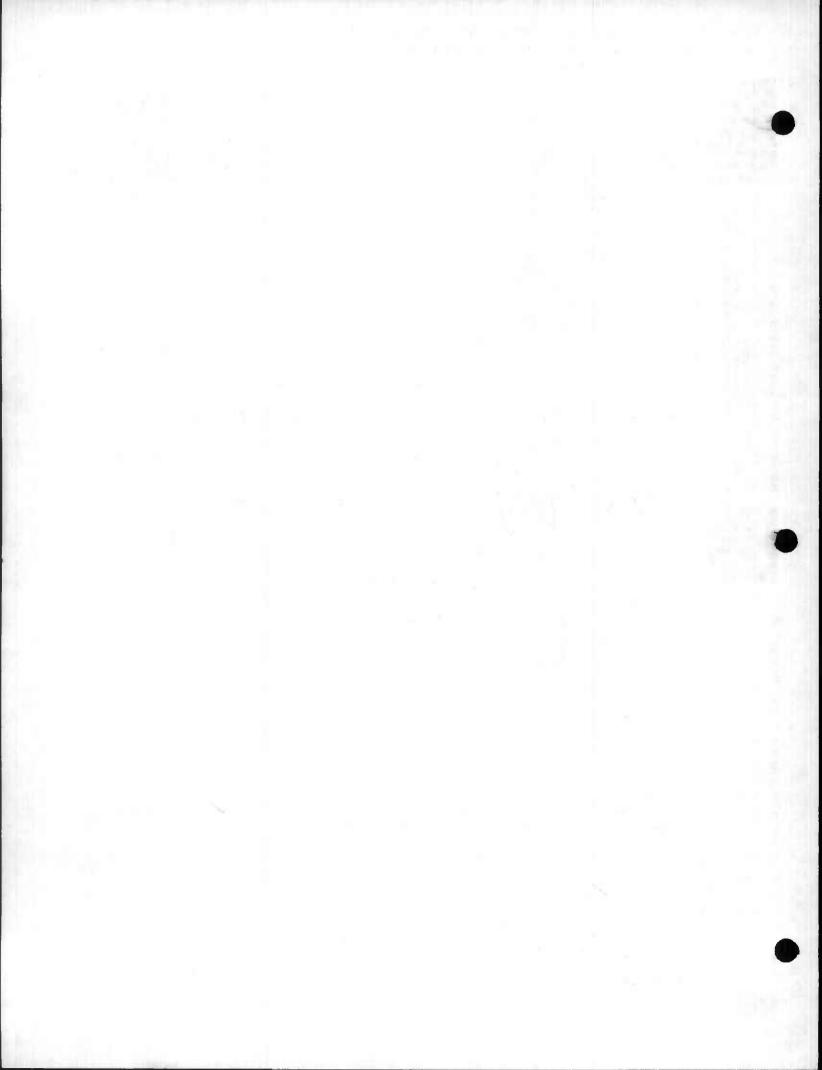
Do 2338

28f. Location (Street end Number or Rural Routa Number, City or Town, State)

29d. Data signed (Month, Dey, Year)

02/03/98

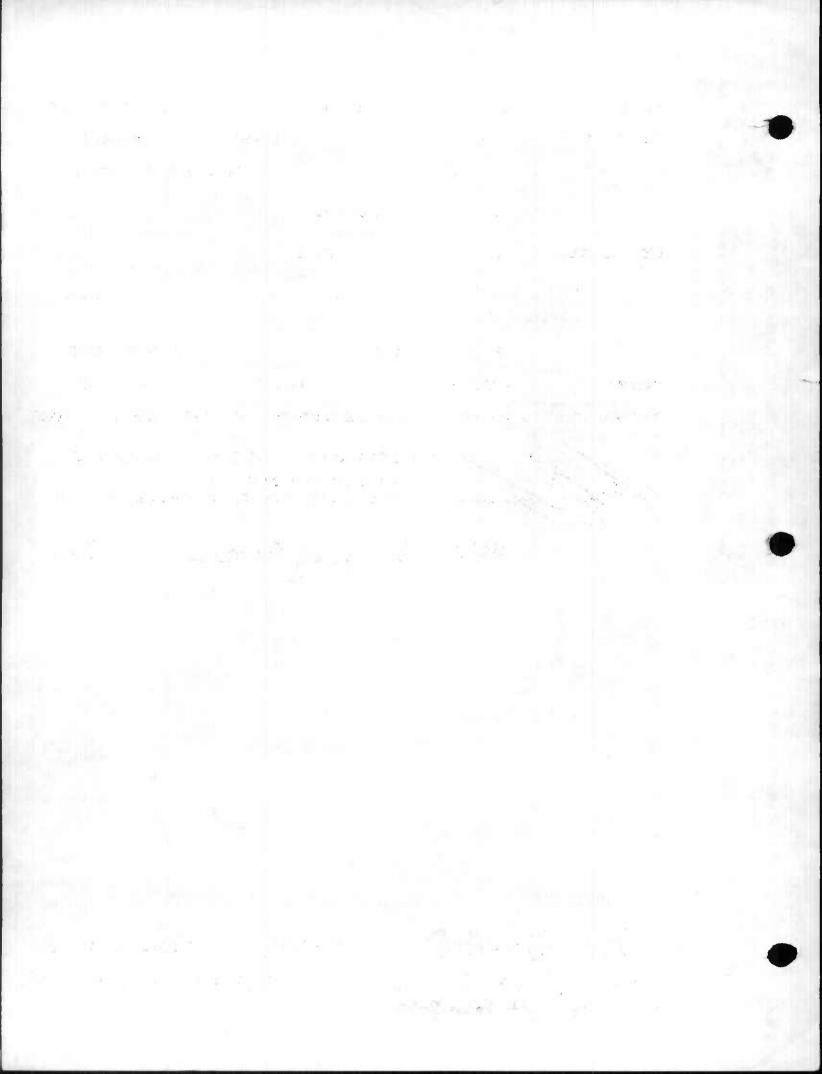
AVE, SILVER SPRING, MD. 20902



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name (First Middle Lest) 2 Date of Death 3 Time of Death Month **Physician** RAYMOND D ZIMMERMAN 1998 MAR 01 3:30 PM /Medical 4b City Town, or Location of Death 4a Facility Nama (If not institution, giva streat and number) 4c. County of Death Examiner 4001 OLD COURT RD., APT. 318 BALTIMORE BALTIMORE If Undar 1 Yaar If Undar 24 Hrs. Birthplece (State or Foreign
Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) **Funeral** Days 1 M 2 □ F Yrs. 85 216-05-3383 Director MARYLAND Usual Rasidenca of Decedent death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show MD BALTIMORE BALTIMORE 1 ☐ Yas 2 XNo Directo 10f. Zip Coda 10e. Street and Number 10g. Citizan of What Country? I is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be a 4001 OLD COURT RD., APT. 318 21208 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural" ~ any injury or other traumatic even. 12. Was Dacedant Evar in U,S. Armad Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status I∏Yas 2∭No IYas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 X No Specify: WHITE Specify þ 3 Widowad 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elamantary/Sacondary (0-12) OWNER EXCELLO LIGHTING 17. Fethar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be **ABRAHAM** ZIMMERMAN REBECCA **FEINBERG** 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) FLORENCE ZIMMERMAN (WIFE) 4001 OLD COURT RD., APT. 318 BALTO., MD 21208 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cree 4 Donation 5 3 Pempyal from State BETH TFILOH CONG. 3/3/98 BALTIMORE, MD er (Sov 21. Signature of SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 ations that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata Intarval Batween Onsat and Daath **Physician** Immediate Ceuse (Final disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of): Physician/Medical Examiner the burial-transit Sequantially list conditions, if eny, leading to immadiata causa. Enter Undarlying Causa (Disaasa or injury thet initiated avants rasulting in daath) Last Due to (or as a consequenca of): physician P.O. Box 6876 Dua to (or as a consequance of): USB 85 ŏ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, q 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s certificate has 1 Yes 2 KNO 1 ☐ Yas 2 ☐ No 25. Wes casa rafarrad to madical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 1 Yas 2 No P 1 Inpatiant 2 ER/Outpatient 3 DOA 5 Rasidance 6 Other (Spacify) After this uneral 27. Mannar of Daath 1 De Maturel Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: or Attending 5 Panding invastigation death. 1 Yas 2 No 2 Accident ofter death Director: 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete) 6 Could not ba determined 3 ☐ Sulcida 28a. Placa of Injury - At home, farm, straet, factory, office building, etc. (Spacify) filled in by 4 Homleide hours e Hospital 24 hours 29a. Certifier 1🕊 Certifying Physician: To tha best of my knowledge, deeth occurred at the tima, dete end plece, and dua to tha causa(s) and mannar as statad. edicai 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end mannar stated. (Check only one) within 2 To the I To the 29d. Data signed (Month, Day, Year) 29b. Signature and titla of cartifian (Itam 23a) (Type, Print) 21239 Baltimore, No 21239 7 State

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Betty Rumbley Brannock Lebruary 0126 AM /Medical 4e. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death tc. County of Death Examiner Hospital Drehester General arkbrides Dorchester If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. last birthday) 9. Birthpiace (State or Foreign Country) Maryland **Funeral** 1 M aXXE Days Yrs. **Director** 217-12-4677 73 Sept Usual Residence of Dacadeni 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes X No Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Buena Vista Avenue 21613 US 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ZANo If Yes, Give Year or Datas: 11 Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Aq Specify **3** Widowed 4 □ Divorcad Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) permit. Pages 1 end 2 should be filed will Depertment of Health end Mental Hygiene Important: If Nem 27 is marked other tha enty Injury or other traumatic event, It all 000.00. Dietary Worker Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Carl B. Rumbley Irene Tyler 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar W. Brannock, Jr Son 1010 Willowmere Lane Cambridge, Maryland 21613 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 2/23/98 MD Veterans Cemetery Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Ligensee 22. Name and Addrass of Facility Thomas Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate

Approximate Approximate Interval Between Onset and Death Physician /Medical Immediate Causa (Final disease or condition resulting in death) **Examiner** Dua to (or as a consequence of) Examiner ician end burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medicai Due to (or es e consequence of): 80 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yss 2 ☐ No Completed by BRONCHITIS /COPO 24b. Wera autopsy findings evaileble prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2□ No 251 or Attending Physician: 25. Was case referred to resolve examiner? Be 26. Placa of Daath (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1¥Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28a. Date of Injury (Month, Dey Year) Mannar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28a. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) filled in by 4 Homicida 29a. Cartifie Medical

Box 68760. P.O. Records, Division of Vital 24 hours after death.

Funeral Director: A Hospital completely within 2

Maryland

Baltimore,

Certifying Physician: To tha bast of my knowladga, daath occurred at the time, date and placa, and due to the causa(s) and manner as stated.

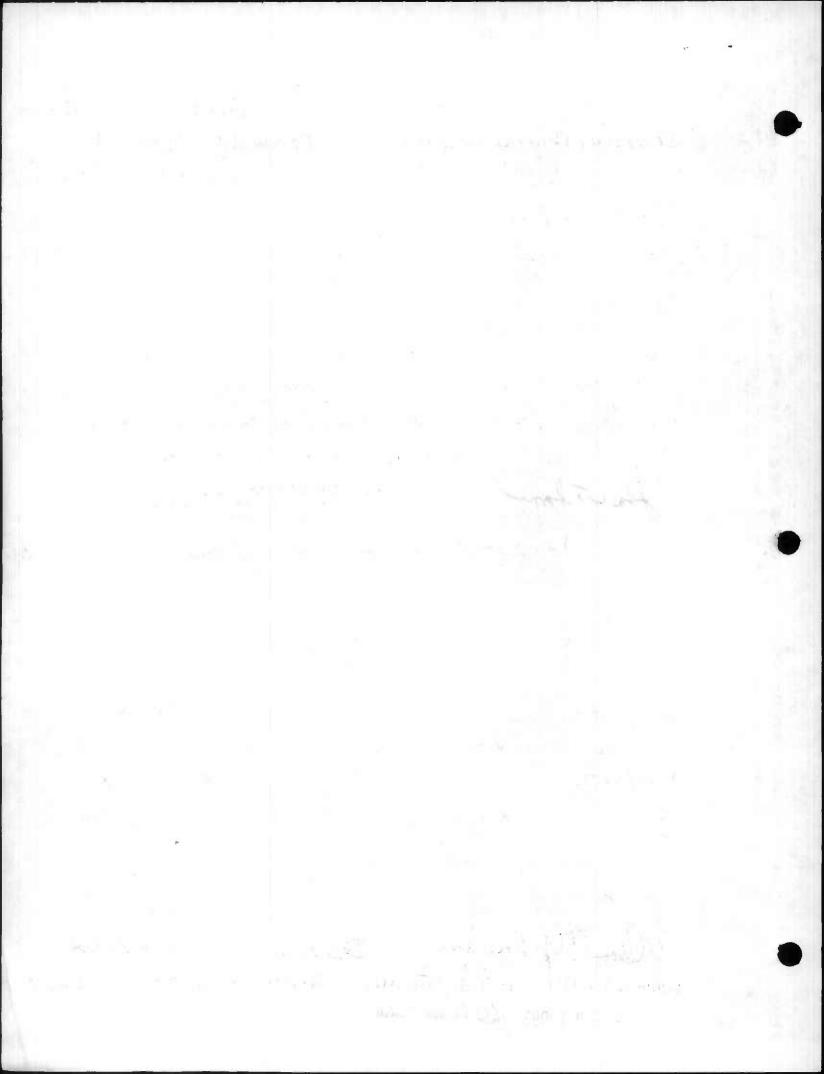
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and due to the cause(s) and mannar stated. (Check only one) 29b. Signature and title of count 29c. License numbar 29d. Date signed (Month, Dey, Yeer)

complated causa of tagth (Item 23a) (Type, Print) 30. Nama and address of parson who (ON

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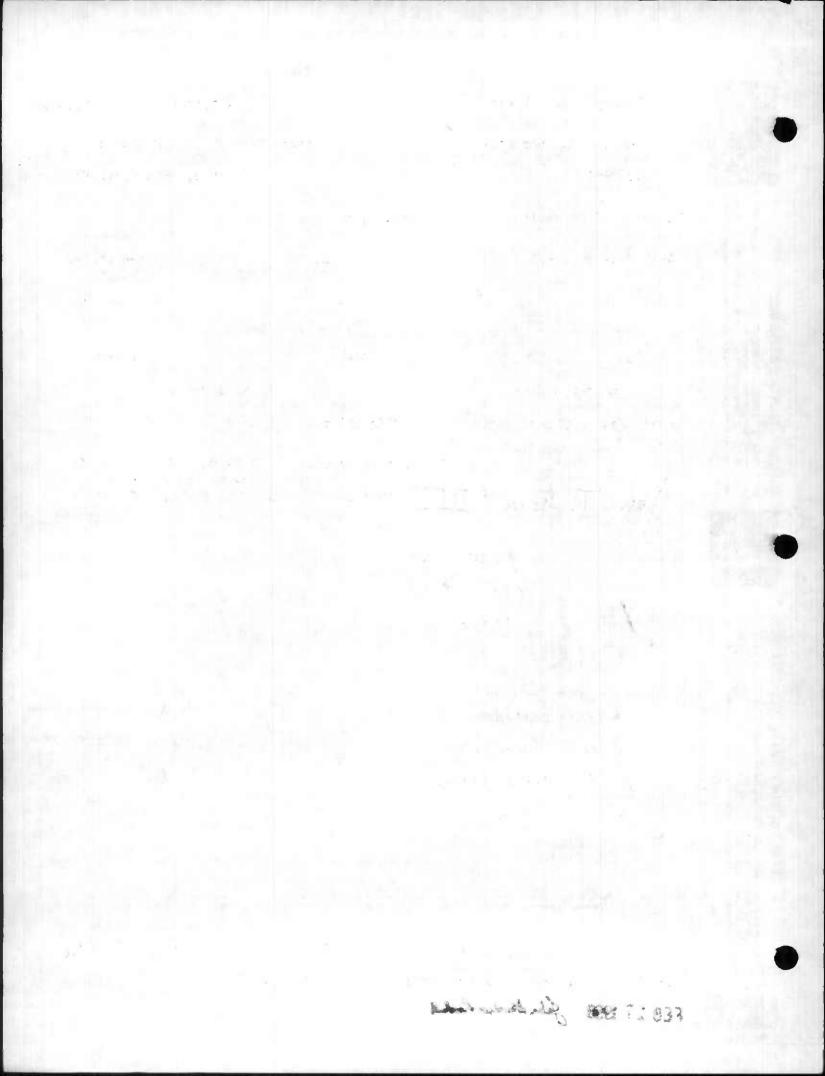
State Registrar

AGUE JR MD
32. Registrar's Signatura 31. Date filed (Month, Day, Year) Jelia Studen Rarbell



State of Maryland / Department of Health and Mental Hygiene

			Certificate	of Death	Re	g. No.	Ub	980			
Physician	1. Decedent's Name (First, Middle, Last, Ramsey N.	Butler			2. Date of Deat Month Feb 7, 19	Day	Year	3. Time of Death 03:05pm			
/Medical Examiner	4a Facility Name (If not institution, give	street end number)		4b. City, Town, or	Location of Deeth	4c. County	of Death				
	Holy Cross H	lospital		Silver S	pring		Montgomery				
Funeral Director	5. Social Security Number 6. Security Number 577-18-3690 Usual Residence of Decedent	7. Age (In yr M 2 F 9]	s. lest birthday) If Under 1 Yrs. Months	Year If Under 24 Hrs Days Hours Min.	8. Date of Birth (Month, Dey, March 3		Country				
nel lend	10a. State 10b. County	10c. (City, Town or Location				100	d. Inside City Lim			
or 28a-f show	District of Columb	oia	Washingto	n				1 ☐ Yes 2□			
vith the Me or 28a-f s be northed Director	10e. Street and Number		10f. Zip C	ode	1:	0g. Citizen of V	Vhat Country	y?			
23a o	4627 Clay St., N.	E.		20019	1	Unit	ed Sta	ates			
urs after dea		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		nt of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	pecify Yes or No- to Ricen, etc.)	14. Race	e - American Indian, ck, White, etc.				
2 ho	15. Decedent's Edu	cation	16a. Decedent's Usual	Occupation	dia	16b. Kind of Bu	siness/Indu	stry			
s 1 and 2 should be filed within 72 ho f Health and Mental Hygiene. fem 27 is merked other than "natur other traumatic event, the Medical To Be Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	(Give kind of work done during most of working life. DO NOT use retired)							
other than vent, tre M	6th	- Consider (1907)	Bis	пор		P	rivate	2			
2 should be filed with end Mental Hygiene. is marked other than aumatic event, the M To Be Comp	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, I	Aaiden Sumem	e)				
should by end Mentalis merked aumetic events.	Ramsey But	ler			Rosa Go	rdon					
2 sho end lis me	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailing Address (Street end Number or Ri	urel Route Number	City or Town,	State, Zip C	Code)			
f Health frem 27 i	Annie Mae Stepher			lem St., Ma	nassas, '	VA 201	10				
Pege ant o ht: If i	20e. Method of Disposition 14 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	Place of Disposition (Neme cemetery, cremetory or oth Et. Lincoln C	emetery	2/14/98	Brent	wood,				
permit. P Departme Importan any injur	21. Signature of Funeral Service Licens	ewal II		Address of Facility Senning Rd.,	N.E. Was			019			
Physician	23a. Part. Enter the disease, or complished, or heart failure. List only or	cations that caused the de ne cause on each line.	alh. Do not enler the mode	of dying, such as cerdia	c or respiretory arre	esi,	1 1	Approximate ntervel Between Onset and Death			
/Medical	Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of):										
Examiner	resulting in death)	Due to				1-1-					
P # P		010	2 Vd								
executed in end in-transit	Sequentially list conditions, figure leading to immediate										
ouriel Ouriel	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Hypert	eNSIBN					YN			
certificate be executed ding physician end se es the buriel-transit	that initiated events resulting in death) Last		(or as a consequence of):								
requires that the death certi een signed by the ettending hould be detached for use e ted by Physiclan/M	Part II. Other significant conditions con	23b. Did to	b. Did tobacco use contribute to the cause of dec								
by by	Lewal f	ailshe			1 🗆 Y	2 No	3 Probe	ibly 4 Unk			
The law require sete has been significant page 2 should I	Atrial	fibrillation	,		24e. Was a perform	n autopsy med?	avail	e autopsy findin lable prior to pletion of cause eath?			
The law sete hes be page 2 s	Pohi U	Lun Dusco	S		1 🗆 Ye	s 2 No	10	Yes 2□ No			
certificate rector, pag	25. Was cese referred to medical	can yere	~	26 Place of De	eth (Check only on	e)					
	eveminer?	lospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ DOA	Other:	Home 5 ☐ Reside		er (Specify)				
After fune	27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		. Injury et Work?	28d. Describe ho						
al or Attendi s after deeth. In Director: A ad in by the fr	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory, city)	office	28f. Location (St City or Town		er or Rurel i	Route Number,			
n 24 hours and n 24 h	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	ician: To the best of my kiner: On the basis of examinend manner stated.	nowledge, death occurred et nation and/or investigation, in	the time, date and place my opinion, death occu	a, and due to the courred at the time, d	ause(s) and ma ate and place,	anner as ste and due to t	ted. he ceuse(s)			
N See See	29b. Signature and title of certifier		29c.	icense number	2	9d. Date signe	d (Month, D	ay, Year)			
1/11	Diamil 9	24 Les	MU	36822		I.L	13	1992			
14/	30. Name and address of person who co	moleted cours of death (th	em 23e) (Type Print)			rep	./				
	David Grossberg m		orgia Ave Sil	ver Spring	20902						
0	31. Date filed (Month, Day, Year)	32. Registra Sig									
State Registrar	FEB 17 1998 8	A STATE OF THE PARTY OF	5.4								



Physician /Medical Examiner physician and the buriel-transit The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a Stele

Director

Funeral

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Funeral

Director

7 is marked other than "naturel", or frams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filled within 72 hours effer c Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or item any injury or other traumatic event, in Medical Exercited. Once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

with the Maryland

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Examiner Physician/Medical p Completed Be 10 Certification:

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Director: After this

Tours Funeral Dir competaty filled in Hospital

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Attending Physician:

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Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

26. Placa of Death (Check only ona)

24b. Were autopsy findings evailable prior to completion of ceuse of death? 1 Ves 2 No 1 Yes 20 No

25. Was cese referred to fiedicel examiner? 1 Yes 2 No 27. Menner Deeth 1 DNatural 5 Pending investigation 2 Accident 6 Could not be 3 Sulcide

31. Date filed (Month, Dey, Year)

4 Homicida

(Check only one)

29a. Certifian

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of

Other: 4□ Nursing Home 5 PResidence 6 □Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated.

1 Yes 2 No

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year) 10

30. Name and address of person who complated ceuse of death (Item 23e) (Type, Print) POIST M. D. 1160

Hospital:

Varnum

20017 Street NE#214, Wash, DC

State Registrar 32. Registrer's Signeture

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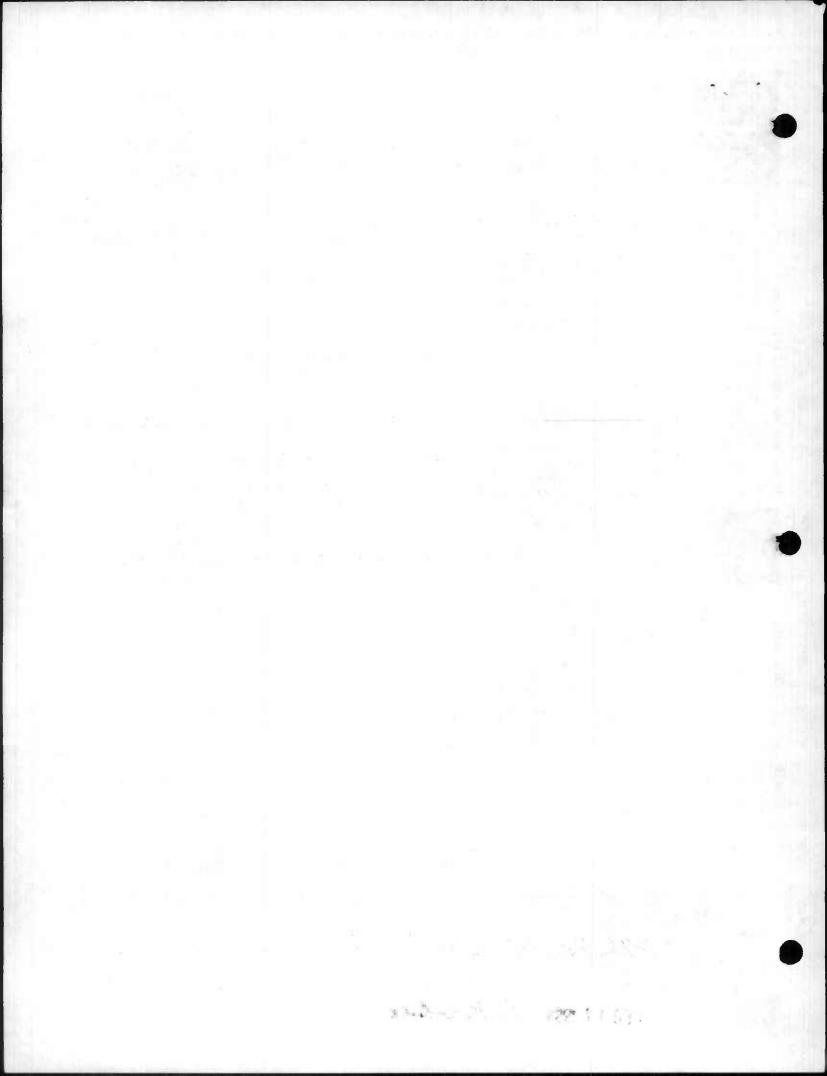
State of Maryland / Department of Health and Mental Hygiene

Physician / Medical Examiner To the Hospital or Attending Physician To the Hospital or Attending Physician To the Hospital or Attending Physician To the Funeral Director			Ce	rtificate o	of Death	R	leg. No.	Ub	982	
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Funeral Director Director	me (If not institution, give	e street end number)			4b. City, Town, or La	ocation of Death	4c. County	of Death		
Director Direct	Blackhawk	Drive			Oxon Hi	11	Princ	ce Geo	rges	
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To the Hospital American Check only one on the Funeral Check only one on the Funeral Check only one) 29a. Certiflier (Check only one) 29b. Signature	5 Pending Investigation		28b. Time of Injury	V	njury at Vork? □ Yes 2 □ No	28d. Describe h	ow Injury occur	red		
29a. Certifier (Check only one) Wedley the complete the		28e. Plece of Injury - building, etc. (Sp	At home, farm, st pecify)	reet, fectory, offic	Ce .	28f. Location (S City or Town	treet end Numb n, State)	er or Rural F	łoute Number,	
0	1 Certifying Phy 2 Medical Exam	ysician: To the best of my niner: On the basis of exar end menner steted.	knowledge, deat ninetion end/or in	h occurred at the	time, date end place, y opinion, deeth occur	and due to the c red et the time, d	ause(s) and ma late end piece,	inner as state end due to th	ed. ne cause(s)	
(3)	end title of certifier			29c. Lice	ense number	2	29d. Dete signe	d (Month, De	iy, Year)	
12	EU)	~		DC.	21143		Februar	ry 13	, 1998	
30. Neme and a	Eliel Baye	completed cause of deeth ever, M.D.	(Item 23a) (Type,	CILL.	ldren's Nat					
State	Month, Day, Year) FB 17 (938)	Registrar's S	ignature eger Raula 11							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended # 19a. Per F.H. P.G.C. 2-24-98 cr 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Physician Month 2-10-98 LOIS BERNICE BAKER /Medical 5:39PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Pk. Md. Motgomery | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Months, Day, Year) | 5 - 21 - 20 5. Social Sacurity Number 9. Birthplace (State or Foraign Country)
Va. 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 X 579 48 9245 Director Usual Rasidance of Dacedent the Meryland 10a. Stata 10h County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f ehov The Medical Examiner must be notified at ¥EXYes 2□No Director Prince Georges Haytsville 10e. Street and Number 10g. Citizan of What Country? death v 6500 Riggs Rd. Funeral 20773 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 (∑No If Yes, Giva Yaar or Datas: 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Black, Whita, atc. 72 hours after 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: P Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grada completed) permit. Peges 1 and 2 should be filed within Department of Heelth end Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic Elemantary/Secondary (0-12) 12 Collega (1-4or 5+) Federal Government Data Systems Analyst 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surname) Be James E. Baker Fannie J. Horn 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Ruth Richardson Buchanan 3102 Barcroft Drive Upper Marlboro Md. 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata XX Rurial 2 Damation 3 Ramoval from Stata Lincoln Memorial Ceme 2-19-98uitland, Maryland 5 Other (Specify ☐ Donation 21. Signature of Puneral Service Light 22. Name and Addrass of Facility
B.F. Taylor Funeral Services Inc. 1722 North Capital Street N.W. 23a. Part1. Enter the disease, or complements that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batw Interval Batween Onset and Daath **Physician** ARTEMOSCIENORI CANDIOVASCULAR DISTASE /Medical Immediata Cause (Final disaase or condition rasulting in daath) Examiner Dua to (or as a consequanca of): Examiner buriel-transit Saquantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Cause (Disaase or Injury that initiated events rasulting in death) Last and Dua to (or as a consequence of) physicien s the buriel Box 68760. certificate be Physician/Medical Dua to (or as a consequence of): 98 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cerebral 1 ~ Farction Records, 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital 25. Was case refarred to medical a 26. Placa of Daath (Chack only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 10 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred or Attending P. sefter deeth. Medical Certification: After 5 Panding Invastigation 1 Natural s efter deeth.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No NIA 2 Accidant 6 Could not ba detarmined 3 ☐ Sulcida 28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida the Hospital within 24 hours of To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and dua to the causa(s) and mannar as statad.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifian (Check only 29b. Signatura and titla of certifiar 29d. Date signed (Month, Day, Year) 29c. License number 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) Ducensbury Rd Hyatto: 1(= MD 20781 VORE, MD DE 32 Ragistrar's Signatura 31. Data filed (Month, Day, Year) State FEB 17 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) **Physician** WILLIAM H. FEBRUARY 12, 1998 1:10AM BOLDEN /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL MONTGOMERY If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) Birthplaca (State or Foreign Country) 5 Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months 1₩ M 2□ F Days 219-05-6512 77 Yrs. MAY 16, 1920 BELLEVILLE, MD. Director Usual Residence of Decedent the Marylend 10d. Inside City Limits r 28a-f show 10a Stata 10b. County 10c. City. Town or Location 1 X Yes 2 □ No Director MARYT.AND MONTGOMERY SILVER SPRING 10e. Street and Number 10f, Zip Coda 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter death with I Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23e or any Injury or other traumatic event, the Modical Examiner must be a 2601 BEL PRE RD. 20906 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 1 Naver Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK g 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grada completed) Elemantary/Secondary (0-12) College (1-4or 5+) PRIVATE MECHANIC 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middla, Last) CLARENCE BOLDEN ESTELLA EHELL. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3940 BEXLEY PL. APT.705 SUITLAND, MARYLAND 20746 JESSIE BOLDEN/ WIFE 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 2/18/98 HARMONY MEMORIAL PARK LANDOVER, MD. 4 □ Donation 5 □ Other (Specify) 21. Signatura of Funeral Service Licansee 22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 MARLBORO PIKE/FORESTVILLE, MD. 20747 Approximate Interval Between Onset and Daath **Physician** /Medicai Immediate Cause (Final disease or condition rasulting in daath) Examiner Examiner physician end the burial-transit that the death certificete be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last onsequence of P.O. Box 68760. Physician/Medical 98 950 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2₽No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of causa of death? wei certificate has b lirector, page 2 s 1 ☐ Yes 2 2 No 1 TVes 2 No or Attending Physician: Be 25. Was casa rafarrad to medical examiner? 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 21 No 2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: Affer 1 Natural 5 Panding 1 Yes 2 No r death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 6 4 Homicide efter ä 24 hours 29a. Certifie 🕊 Certifying Physician; To the best of my knowledge, death occurred at tha tima, data and placa, and due to tha cause(s) and mannar as stated. edicai completely 2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only To the I within 2 29b. Signature and titla of certifia 29c. Licensa number 29d. Date signed (Month, Day, Year)

Registrar

31. Data filed (Month, Day, Year)
FFR 1 7 1998

ess of person was completed

32 Registrar's Signature

LACK

PRIVATE

STELLA EUELL

LALEY PL. APT. 705 SUITLAND, MARYI

JARMONY MEMORIAL PARK 2/18/98 LANDOV

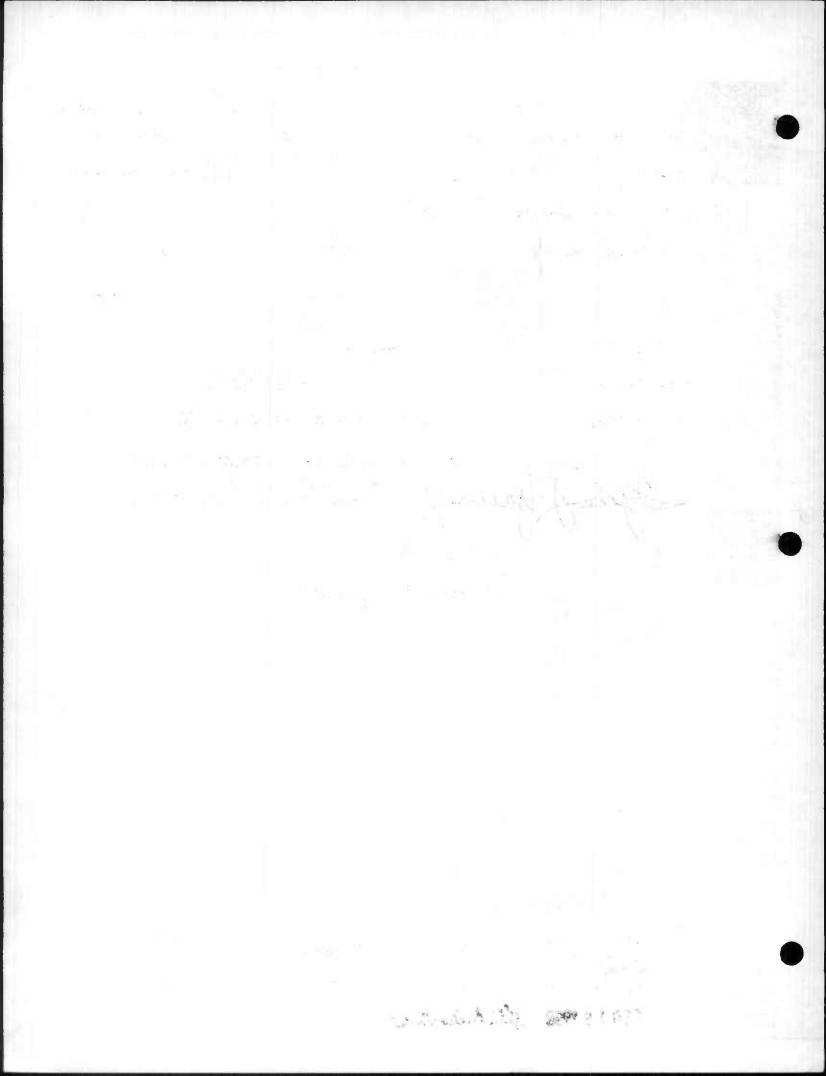
ALEXANDER S. POPE FUNERAL HOW 5538 MARLBORO PIKE/FORESTVIL

58014 No

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State of Maryland / Department of Health and Mental Hygiene

						(Certifica	ate of		Monta, 119	Reg. No.	3 0	698	35		
Dhu	-1-1		1. Decedent's Nama (First, Middla,	Last)						2. Dete of De Month	eth	Year	3. Time	e of Death		
	sician edical		JANNIE	BEATTY						02	Day 12	1998	6:48	A.M.		
	miner		ta. Fecility Name (If not institution, Prince George's Com				4b. City, Town, or Cheverly	Location of Death		nty of Death CE GEOI	1					
Fune Direc			5. Social Sacurity Number 578–34–9631 Usual Residence of Decedent	5. Sex 1 M 2 ▼ F	7. Age (In yrs 69		Months Days Hours Min. (Month, Day, Year)					9. Birth Cou Ande	9. Birthplece (Stata or Foreign Country) Anderson, SC			
Menylend ehow	1		10a. State 10b. County MD Prince G	eorge's		ity, Town	or Location							City Limits		
with the N	Funeral Director		10e. Street and Number 4814 Tuckerman Stre	æt			10f. 2	Zip Code 2073	7		10g. Citizen o	of What Cou				
Baltimore, Maryland 21215-0020 pernit. Pages 1 end 2 should be filed within 72 hours after death with the Merylend Department of Health end Mental Hygiene. Important: If Nem 21 is marked other than "natural; or Nems 23s or 28s-7 show highly or on the trainmaft ovent. The Medical Property is sent to the property of th	by Funera	2	11. Marital Status 1 □ Nevar Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	Armed For	es 2 No , Give or Dates:		13. Was Decedent of If Yas, specify Cu 1 ☐ Yes 2 N N		of Hispanic Origin? (Specify Yes or uban, Mexican, Puarto Rican, etc.) No Specify:			lace - Amar leck, White city: Bla	e, etc.	,		
5-0 72 hc	je d		15. Decedent's (Specify only highest	Education		16e. [16e. Decedent's Usual Occupation (Giva kind of work done during most of work life. DO NOT use retired)			rkina	16b. Kind of	Business/I	ndustry			
21215-0020 d within 72 hours af giene. rr than "netural", or	Completed	2	Elementery/Secondary (0-12)	Collega (1	-4or 5+)		life. DO NOT Housew		ed)	9	Home					
d be filed antal Hygin	o Be C	3	17. Father's Neme (First, Middle, La Rufus Ellington	ist)		1				me (First, Middle, Roberson	OW N Maiden Sum					
Maryland nd 2 should be file lith end Mental Hy 27 le marked othe	To.		19a. Informent's Neme/Relationship Patricia Beatty	(Type, Print)					#3 Rivero			m, State, Z	ip Code)	1.00		
Baltimore, Permit. Pages 1 er Department of Hea mportant: If Item;					20e. Method of Disposition 1 🖾 Buriel 2 🗆 Cremation 3 4 🗆 Donation 5 🗀 Other (Spa	cem etery	Disposition (A crematory o	r othar pi		Date 2/19/1998	20c. Locatio		own, State			
Baltii permit. F Departm Importar	ouce.		21. Signatura of Funeral Service Li	1 1	IND)	Nacre	22. Name TYRONE	and Add	ress of Facility OUNG FUNERA Street, N.	L SERVICE		011				
Physicia /Medic Examin	al er	1	23a. Part1. Exist the disease, or o shock, or beart failure. List of limited and limited a	implications that of ly one dauge on ea	andia		Accordance of		ring, such es cardie	c or respiretory a	rrest,		Approxin Interval I Onsat ar	mate Between nd Death		
I RECORDS, P.O. BOX 58/60, The law requires that the death cartificete be executed attents been signed by the attending physician and and 25 should be deteched for use as the buriel-transit	12	vmedical Examine	Vinedical Examine	Inmedical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Lasl	c	Due to (or as a co	insequence of	0:) (42					
BOX death cert attendin d for use	clar	-	Part II. Other significant condition	a contribution to do	oth but ool so	nulting In 1	the undertuled		ives to Deet I	One Didases and Adams and Adams						
dS, P.O. I uires that the dea signed by the a	/ Phys		Part II. Other significent conditions	r contributing to de	atti but noj ra:	suiting in	me underlying	causa g	iven in Pan I.	23b. Did tobacco use contribute to th				/		
Records, he law requires the hes been signed 2 should be contacted.	piete									24a. Was	en eutopsy med?	0	Vere eutop: veileble pri completion of death?	ior Io		
The ta	E									10	Yes 2 No	1	☐ Yes 2	2□ No		
of Vital Physician: The this certificate ral director, page	Be		25. Was case referred to medical exeminer?		/				26. Place of De	ath (Check only o	one)					
- K 50 0			1 Yes 2 No			ER/Outp	patient 3 1	OOA	ther: 4 Nursing F	dome 5 Resid	dence 6 🗆 C	other (Spec	rify)			
VISION O Attending Ph or death. ector: After th by the funeral	ation:	1	27. Menner of Deeth 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investiga:		f Injury h, Day Year)	28b. Tir Inj	me of ury M	28c. Inji W	uryet ork? ⊒Yes 2 □ No	28d. Describe	how injury occ	urred				
2 4 2 2 5	· =		3 ☐ SuicIde 6 ☐ Could no 4 ☐ Homicide determine	ed 288. Place	of Injury - At h	ome, fam fy)	n, street, facto	ory, office)	28f. Location (: City or Tox	Street and Nu	mber or Ru	ra / Route N	lum <i>ber</i> ,		
To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edicai		29a. Certifier 1 ☐ CertifyIng (Check only one)	Physicien: To the i	sis of examina	owledge, ation end/	death occurre or Investigation	d et lhe t on, in my	time, date and place opinion, deeth occu	e, end due to the urred at the time,	ceuse(s) and date end plec	manner as a, end due	stated. to the ceus	ie(s)		
To the To the	X e		29b. Signature end title of certifier	. 0					nse number		29d. Date sig	ned (Moralh	, Day, Yea	r)		
6			May Di	The	mo			D-6	8890200		1/	17/0	18			
9			30. Name and address of person wh	o completed cause	of death (tte		ype, Print)	~ S	L NE L	Nash 1) (Ju	017				
	State istrar		31. Date filed (Month, Day, Year)	32, Re	egistrer's Sign	ature						4				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. FOUNT? Day 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 05:30 pm VERNE BAKER HARRY 08 FERRUARY 4a. Facility Name (If not institution, give street and number, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Annths Days Hours Min. April 5, 4b. City, Town, or Location of Death 4c. County of Death 1407 Southern AVENUE # 104 PRINCE GEORGES 5. Social Security Number 6. Sex 1 M 2 F 9. Birthplece (State or Foreign Country)
Virginia 7. Age (In yrs. last birthday) Year) 1931 66 Yrs. 578-40-2787 Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1407 Southern Avenue, #104 20745 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1948—52 Year or Dates 1948—52 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorcad 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Painter Commercial Painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown Unknown Unknown 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1407 Southern Ave. #104, Oxon Hill, Md. 20745 John Corbin/Friend 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Defiation 5 ☐ Other (Specify) Maryland Veterans Cem. 2/18/98 Cheltenham, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home, Md.20745 erf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, hock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Ceuse (Finel · ARTERIOSCIEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Due to (or as a consequence of) Due to (or es e consequence of) Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

Physician /Medical **Examiner**

requires that the death certificate be executed

ate has been signed by page 2 should be detac

certificate has

funeral

filled in by

I or Attending Physician: effer death. Director: After this certifica

Hospital 24 hours e n 24 hours

To the Hosp within 24 hou To the Funer completely fil

Division of Vital

þ

Completed

Be

2

Certification:

Medicai

Physician

/Medical

Director

Funeral

þ

Completed

Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer c Depertment of Health and Mentei Hygiene. Important: if Nem 27 is marked other than "natural", or Nem any injury or other traumatic event, the Medical Exempted

Baltimore, Maryland 21215-0020

deeth with the Merylend

Examiner physician and the bunai-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Physician/Medicai 88

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

examiner? 1 Yes 2 No 27. Manper of Death

1 Natural
2 Accident 5 Pending investigation 3 ☐ Suicide 4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HOSPITAL DRIVE, CHEVERLY, MAKYLOND 20185

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

29c. License number

3061

29d. Date signed (Month, Dey, Year) FEBRUARY 9, 1998

State Registrar

GOLLE

32 Registrar's Signature

impleted cause of death (Item 23a) (Type, Print)

JY-

AND AND ALGER

		Decedent's Name (First, Middle, La.	erl		Cer	tificate of	Death	Mental Hyg	Reg. No.	U	987				
Physicia		Anna		nson				Month O2	Day 17	Year 98	3. Time of Death				
/Medica Examine		4a. Facility Name (If not institution, give					4b. City, Town, or			y of Death	4:55 PM				
Examine	٠,	Prince George's	Hospita:	1			Chever	cly	Prin	ce Ge	orge's				
Funeral Director		5. Social Security Number 227–38–4852 Usuel Residence of Decedent	ex 7. A □ M 2 □ XF	Age (In yrs. 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h /, Year) -16	9. Birthp Coun Vir	lace (State or Fore try) ginia				
show	2	10a. State 10b. County Maryland Prince G	eorge's	10c. City	y, Town or Lo		andover		10d. Insid						
death with the Maryland rns 23e or 28s-f show rnvart be notified at	Funeral Director	10e. Street and Number 2720 Kelner Dri				10f. Zip Code	20785		10g. Citizen of	What Coun	1)X Yes 2				
urs after	by	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	? KNo	H	Vas Decedent of H Yes, specify Cube	fispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Re Bla Specia	te - Americ ck, White, fy: B1					
- c - 3	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-40)	r 5+)	16a. Deced (Give i life. E		during most of wo d)	rking	16b. Kind of E		,				
filled with Hygiene. ther ther	ပိ	17. Father's Name (First, Middle, Last)				Houseke	-	me (First, Middle,		Priva	te				
ges 1 and 2 should be filled within to Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, in it.	To Be	Hosea Fitchett						irginia I							
d 2 should be file th and Mental Hy 7 is marked othe traumatic event		19a. Informant's Name/Relationship (7					end Number or Ri	ural Route Numbe	r, City or Town	, State, Zip					
Health Health Health Her to		James Benson Jr. 20a. Method of Disposition	/Husband	20h P		Kelner I	Orive, 1a	andover,	Maryla 20c. Location						
Positinical permit. Pages 1 er Depertment of Hea mportant: If Item. any Injury or other ance.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		e Ci	ametery, crem	Cemetery		2/24/98			Maryland				
permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 is eny Injury or other trait		21. Signeture of Funeral Servica Lican Churles J 23a. Part1. Enter the disease, or compshock, or heart failure. List only	1			Name end Addre	onking Fi	uneral Ho	ome						
flicate be g physicia as the bur	Physician/Med	edical	edicai	edicai	edical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last	a. Is de b. Ca c. 11	yper	r as e consequence of the conseq	nin	disco Caldo	e disc	les	pits	
law requires that the death cert set been signed by the attendin 2 should be detached for use.		Part II. Other algnificant conditions co				derlying ceuse giv			obacco ues co		the cause of dea				
he law requires the e hes been signed age 2 should be def	Completed by	,						24a. Was a perfor	in autopsy med?	eve	re autopsy finding pileble prior to appletion of cause death?				
- # a	_							1 🗆 Y	es 2XNo	1□	Yes 2□ No				
Physicien: The this certificate ral director, pag	o Re	25. Was case referred to medical examiner?	Hospital: 🗸			oc och	00	ath (Check only or							
	- -	1 Yes 2 No 27. Manner of Death	1 Inpat	ury	ER/Outpatient 28b. Time of	3 DOA 28c. Injur	4 U Nursing F	fome 5 ☐ Resid			')				
tending Ph leath. tor: After th the funeral	ation	1 Natural 5 Pending 2 Accident investigation	(Month, D	ay Year)	Injury	Wor	k? Yes 2 □ No	1	IA.						
To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funeral Certification.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Ir building, e	njury - At hor	me, farm, stre	et, factory, office		28f. Location (S City or Tow		ber or Rura	Route Number,				
To the Hospital within 24 hours a To the Funerel Completely filled	edicai	29a. Certifier (Check only one) Certifying Phy	rsician: To the best iner: On the basis of and manner s	of examinati	vledge, death on and/or inve	occurred at the tin estigation, in my o	ne, date and piece pinion, death occu	, and due to the c rred at the time, d	euse(s) and m late and place,	enner as st and due to	ated. the ceuse(s)				
To the within 2 To the comple		29b. Signature and fittle of certifier		. 1	(M)	29c. License	1286	3	9d. Date signe	od (Month, L	Day, Year)				
(15)		30. Name and address of person who of the MOLOCVI THE 31. Date filed (Month, Day, Year)	ompleted cause of	death (Item	23a) (Type, F	rint) aver Rd	Cher	only 14	0 6	207	85				
	9	31. Date filed (Month, Day, Year)	32 Regist	rar's Signat	ure										

					C	ertificate of	Death		Reg. No.	j U(0988
Physi /Med		1. Decedent's Neme (First, Middle James Le		n, Sr.	34-			2. Dete of De Month Febru	ath Day ary 14,	Yeer	3. Time of Deeth 7:05pm.
Exam		4e. Facility Name (If not institution	, give street end nu	mber)			4b. City, Town, or Lo				
Funera Directo	_	5. Social Security Number 579 – 16 – 7749	munity H 6.Sex 123M 2□F	ospita. 7. Age (In yrs 75		y) If Under 1 Year Months Deys		8. Date of Bir (Month, De	1		rge's Co. co (State or Foreign land
pug *		Usuel Residence of Decedent 10a. Stete 10b. County		10c C	ity. Town or	Location				104	1. Inside City Limits
the Maryland r 28a-f show	tor	Md.	P.G.		ando					100	1 Yes 2 No
or 28	ire	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Country	y?
() () () () () () () () () () () () () (<u>a</u>	7701 Gre	enleaf E	Rd.		20	785		U	.S.A.	
POUND SR	by Funeral Director	11. Maritei Stafus 1 Never Married 2 Merr 3 Widowed 4 Divorced	12. Was Dece Armed Fo ided 121 Yes If Yes, Gin Year or D	ve i*	45	3. Was Decedent of If Yes, specify Cub 1 Yes 2 XNo	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rad Bie Specif	ce - American ck, White, etc y:	
15-0/15-0 in 72 hou	Completed	15. Deceden (Specify only highes	it grede completed)		16e. Dec	cedent's Usual Occu ve kind of work done DO NOT use retire	pation during most of work ed)	ing	16b. Kind of B	usiness/Indu	stry
1 . J. CA	E	Elementery/Secondery (0-12)	College (1	1-4or 5+)		intenanc			Privat	te In	dustry
iore, Maryland 2 iore, Maryland 2 ges 1 and 2 should be filed to fleath end Mental Hygins If item 27 is marked other or other traumatic event, u	To Be C	17. Fether's Neme (First, Middle, Arthur Bro					18. Mother's Name	e (First, Middle, Diggs			auscry
Maryla Maryla d2 should be end Men		19e. Informent's Name/Reletions Janice A. Br		hter		-	tend Number or Run		er, City or Town	Stete, Zip C	ode)
L(F)		20e. Method of Disposition	own, baag			position (Neme of remetory or other pla		Dafe	20c. Location	- City or Towr	n. State
Baltimore, semit. Pages 1 ar Department of Haa mportant: If Item in the Internation of the Internation of the Item in the Internation of the Item in I		1 XBuriei 2 Cremetion 4 Donetion 5 Other (S)		State Ch	elter	ometory or other pla ham Vet	's. cem.	24/98	Chelter		
Baltime Bernit. Pag Depertment Important: H any Injury o	3	21. Signeture of Funeral Service				22. Neme end Addre	ess of Fecility				
Baltim pomit. Pag Depertment Important: I	SUISE	Vary.	w.Q.	ATT		H.S.Wa	shington urroughs	& Sor	ns Co.	Inc.	
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/Medica Examine		Immediate Cause (Final disease or condition resulting in deeth)	e			CANO	LER				1997
B 15	Examiner		b. F	Nei	or es e cons	NIA				3	Fel 98
68760, tificate be executed gphysician end as the burial-trensit	edical Exar	Sequentially llsf conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	c)(AC	or as a cons C + or es e conse	es 1	relli	ZUT		1	985
Box (eath certif	-		d							i	
Vision of Vital Records, P.O. Box Attanding Physician: The law requires that the death certing the death certise the this certificate has been signed by the attending by the funeral director, page 2 should be deteched for use a	y Physician/N	Pert II. Other significant condition	A.	eath but not re	suiting in the	underlying cause gi	iven in Pert I.		tobacco use co Yes 2□ No	ntribute to the	he cause of death?
Division of Vital Records, P.O. to Attanding Physician: The law requires that the diaffer death. Director: After this cardificate hes been signed by the time the tuneral director, page 2 should be deteched in by the tuneral director, page 2 should be deteched	Completed by	Corons	ing f	INTE	ENR	DIS-	ease		en eutopsy emed?	aveile	e eutopsy findings eble prior fo pietion of cause eth?
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Of Physic of this of ral directions of the control	-T	1 Yes No	Hospital: 128a. Dete		28b. Time	ent 3LI DOA	-		dence 6 Oth		
On ding th.	tion	Neturel 5 Pending	(Mont	th, Dey Year)	Injury	Wo	ork? Yes 2 No	200. Describe	now injury occur	180	
Division of the Hospital or Attanding Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Piece	of Injury - At h ng, etc. (Speci	nome, farm, s ify)	street, factory, office		28f. Location (City or Tox	Street and Numi vn, Stete)	ber or Rurel F	Route Number,
P Hospita 24 hours P Funeral etely fille	Medical C		xaminer: On the ba				ime, dete end plece, opinion, deeth occurr				
To the within To the	Me	29b. Signature and fitte of certifier	> A/	1 /		29c. Licen	se number		29d. Dete signe		
		I Jenel 2	a July	w		D26	5554		02-	15-	98
		30. Name and address of person	who completed caus	se of deeth (Ite	m 23a) (Type	e, Print)	21 FRACE	01	rocks	ville,	M3
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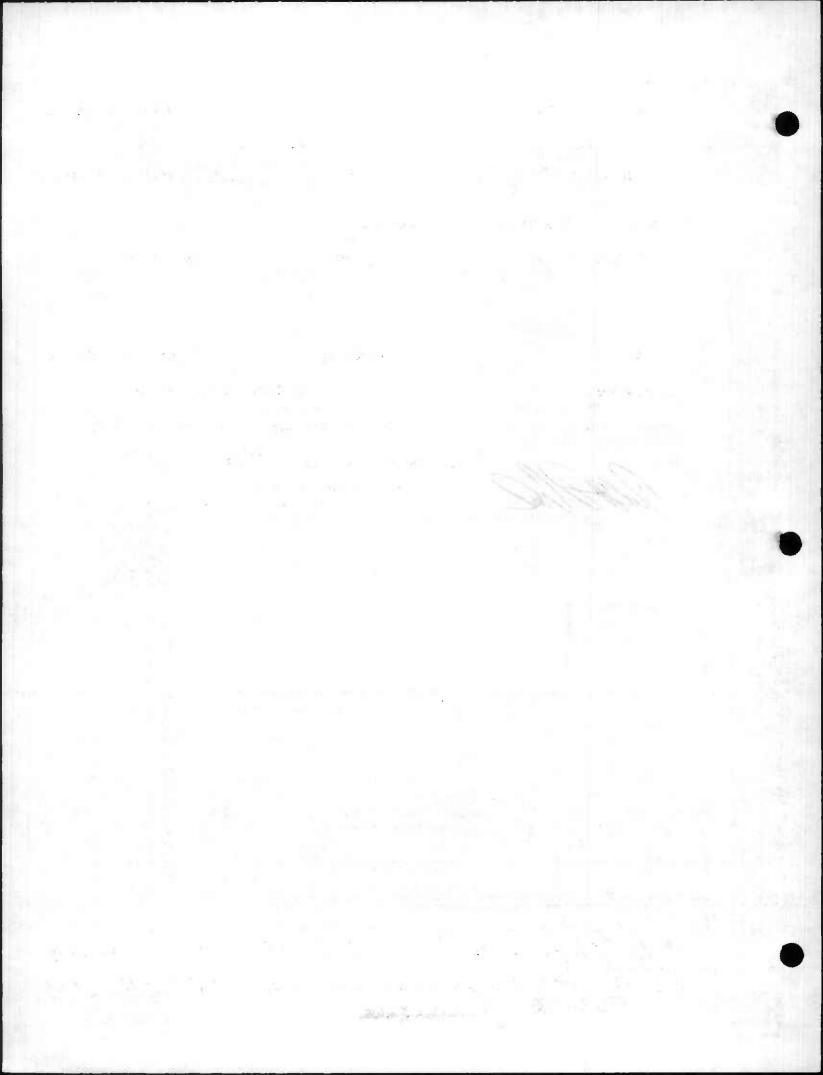
Registrar

FEB 19 1998

THE LEWIS AND ASSESSED.

State of Maryland / Department of Health and Mental Hygiene

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Physicia	n							2. Data of Daa Month	-		Tima of Death
/Medica	ai		mba					F-ebrua	Day 23,	1998 1	4:10
Examine	er	4a. Facility Nama (If not Institution,	giva street end numbe	r)			4b. City, Town, or L	ocation of Deeth	4c. County	of Death	
	Ц	23 Cedar Lane						East	Ce	cil	
uneral		Social Sacurity Number	5. Sax 7. A 1 ☑ M 2 ☐ F	Aga (In yrs. les	st birthday) If Ur Mont	nder 1 Yaar ths Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day	Yaar)	9. Birthplace	(Stata or Fore
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0 8 0		10e. Street and Numbar			10f.	Zip Coda		1	10g. Citizen of \	What Country?	
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other t	3	9			Sho	emake				Shoe R	epair
	ne	17. Fathar's Name (First, Middla, La	st)				18. Mother's Nam	na (First, Middla,	Maidan Surnam	ne)	
marked or	0	Anthony Bomba					Josephin	e De Pau	lantin	0	
ls ma		19a. Informant's Name/Reletionship	(Type, Pnint)		19b. Mailing Addr	rass (Street	end Number or Ru	ral Routa Numbe	r, City or Town,	State, Zip Code	a)
em 27 l		James V. Bomba	/ Brother		2360 Pu1	aski I	Highway,	North F	est. MD	21901	
item 27 other to		20a. Mathod of Disposition	DIOCHEL	20b. Plac	ca of Disposition (Nama of		Data	20c. Location -	City or Town, S	Stata
int: If its		1 ☐ Burial 2 🖾 Cramation 3		а	netery, cramatory		11	Teb. 24 V	West Ch	ester,	
njur.	-	4 Donation 5 Other (Spe	1//	R.A.	Ferris		cory	1998	Penns	ylvania	
Important: If I any injury or once.		21. Signature of Funeral Service Lic	00000				ss of Facility neral Hom				
= 4 0		1/lds/7/-/	160				Main Stre		th Fact	MD 2	1901
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sician	1	SHOCK, OF HABIT FAILURA. LIST OF	ny ona causa on aach	III a.						Ons	vel Batween et end Death
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rurara urector Atle firs certificate has been signed better the property of the funeral director, page 2 should be diffical Certification: To Be Completed by	medical certification. To be completed by	Sequentially list conditions, if any, leeding to Immediata causa. Entar Undarlying Cause (Disaase or injury thei initiated evants resulting in deeth) Lest Part II. Other significant conditions Part II. Other sig	b	Dua to (or as Du	s a consequence of se conseque	DOA Other 28c. Injun World 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	28. Place of Deal er: 4 □ Nursing Ho y at k? Yes 2 □ No	1 Yes e parlors 1 Yes e parlors 1 Yes th (Check only on one 5 Raside 28d. Dascribe house 28d. Dascribe house 28d. Location (St. City or Town and due to that circle et that time, de 2	es 21 No en autopsy mad? es 21 No es 21	ar (Specify) red ntribute to the and are as stated, and dua to the conditions are as stated.	cause of dea 4 Unkn utopsy finding a prior to ion of causa? 2 No ta Number, cause(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dele of Deeth 3. Time of Death **Physician** Month BARANOSKI MARIE FEBRUARY 6,1998 0339 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner GENERAL HOSPITAL BERLIN WROCESTER ATLANTIC 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 1 M 28E Deys Yrs. Director 32-24-7141 65 the Maryland 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23e or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Mp. WORCESTER OCEAN CITY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12 52ND STREET 21842 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 20 No If Yes, Give Yeer or Deles: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐No Specify: by Specify: WHITE 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then any injury or other traumeti. Elementery/Secondary (0-12) College (1-4or 5+) EXEC. SECRETARY EDUCATION 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) WICINSKI CHESTER ANN FLORKIEWICZ 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) HENRY BARANOSKI STREET OCEAN CITY, MD., 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State Buriel 2 Cremetion 3 Demovel from State 4 ☐ Donetion 5 ☐ Other (Specify) PETERS CEMETERY 2-10-CASTLETON, 22. Name and Address of Fecility ULLRICH FUNERAL HOME BERLIN, Mp., 21811 23e. Prov. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) **Examiner** Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the bause of death? Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably by Completed 24b. Were eutopsy findings evellable prior to completion of ceuse of deeth. 24a. Was en eutopsy performed? 2 NO 2 No Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) 1 ☐ Yes 2No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 28 ER/Outpatient 3 ☐ DOA to 華 Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After Division 5 Pending investigation Neturel V 1 Yes 2 Accident Director: 3 ☐ Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) after 4 Homicide 6 To the Hospital willin 24 hours a To the Funeral C Hospital Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end magner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name end eddres

who Davidson

Registrar

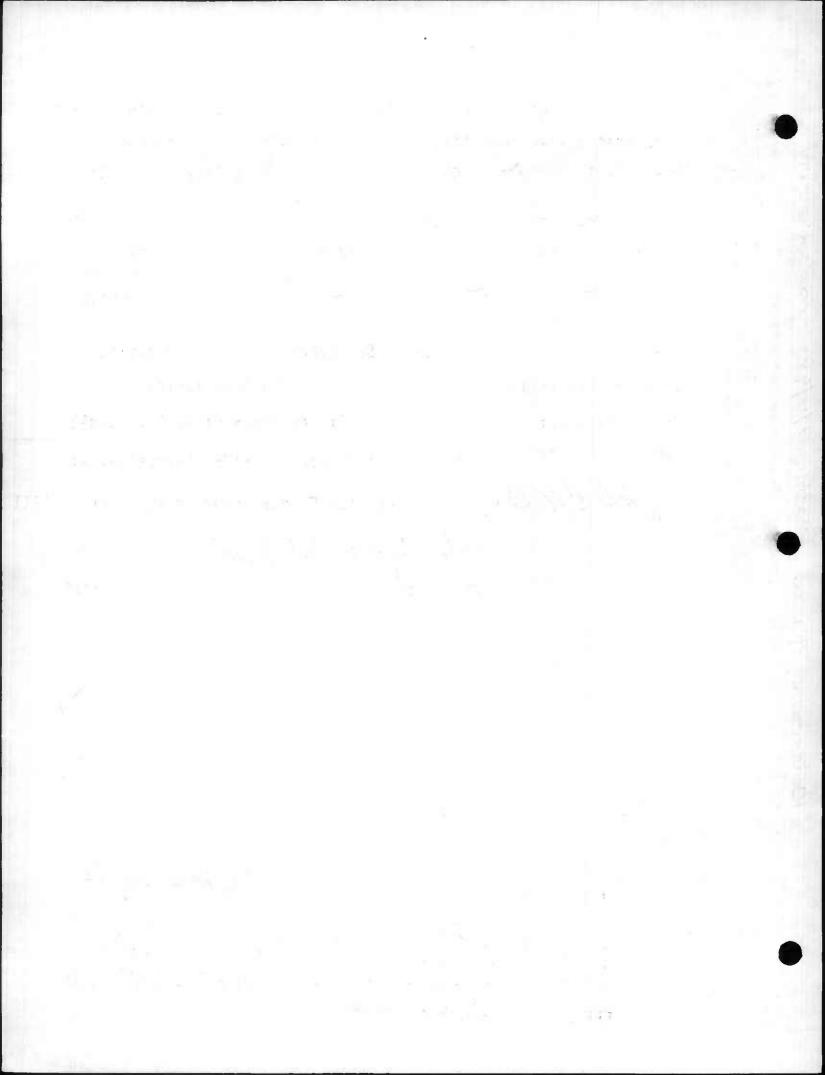
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31. Dete filed (Month, Dey, Yeer)

FEB 06

3

3



State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Month Dolde 20,1998 0:00 PM Febr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGE Hours Min. 8. Data of Birth (Month, Day, MAY 7, 6. Sex 1 ☑ M 2 ☐ F If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Months Days MARYLAND Yrs **Director** 578-07-5426 80 Usual Residence of Dacedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner raunt be notified at TE Yes 2 No Director MARYLAND PRINCE GEORGE BRANDYWINE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò 20613 12425 LUSBY LANE UNITED STATES items 23a death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 (2) Yes 2 □ No If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: by Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Peges 1 and 2 should be filed within nent of Heelth end Mental Hyglene. Int: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE BOILER FIREMAN GOVERNMENT 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) HARRY BOLDEN HARRIETT GANT BOLDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Peges 1 and 2 s Department of Heelth er Important: if Item 27 is any Injury or other trau once. 7745 HAWTHORNE ROAD, LA PLATA, MARYLAND HARRY BOLDEN / SON 20646 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetary, cramatory or other place) 20c. Location - City or Town, State 1 Burlal 2 ☐ Cremation 3 ☐ Ramoval from State 4 Donation 5 Other (Specify) MARYLAND VETERAN CEMETERY 2/27/98 CHELTENHAM, MARYLAND 21. Significant of Funeral Service Licensee 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. THORNTON JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 2064D C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) **Examiner** Accidents bunal-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue P.O. Box 68760, SISSIEDOL Physician/Medical the Dua to (or as a consequenca of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ cate hes been sig ; page 2 should b Be Completed 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? completion of cause of death? 1 Yes 2 NO 1 ☐ Yas 2 ☐ No this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

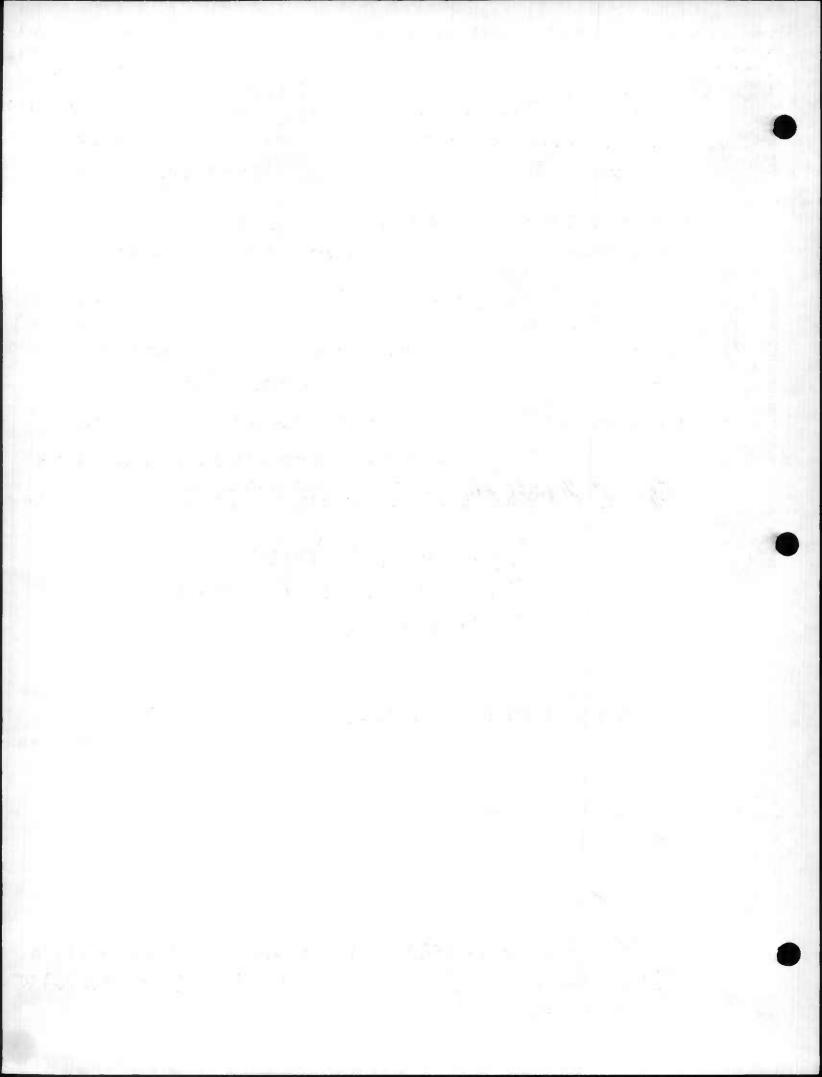
To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner-of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending invastigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piace, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of ced 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar ohn

31. Date filed (Month, Day, Year)

32. Registrar's Signature
Sulva Dhumban Randak

writts Rd. #201A Clinton Md 20735



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** Month DOROTHY PHILOMENA BRUBACH 5:35 PM 2 18 98 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ocean City Worcester 14006 Sea Captain RD If Undar 1 Yaar If Undar 24 Hrs.
Months Days Hours Min. 5. Social Sacurity Number Data of Birth (Month, Day, Year) 4/29/17 Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) Days 1 □ M 2 K F Yrs. 215-40-4699 80 OH Usual Rasidanca of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. tnslda City Limits Director MD Worcester Ocean City 1 □XYas 2 □ No 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 14006 Sea Captain RD 21842 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 🖔 No If Yes, Giva Yaar or Datas: 1 ☐ Navar Marriad 2 ☐ Married 1 Yas 2 No by Specify: 3 Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 18b. Kind of Businass/Industry Collega (1-4or 5+) Elemantary/Secondary (0-12) School Teacher Education $5 \pm$ 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) Be Herman C. Baker Amelia Schott 19a. Informant's Name/Raiationship (Type, Print) 19b. Malting Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Rose Chester/ Daughter 720 139th St. Ocean City, MD 21842 20a. Mathod of Disposition 20b. Piace of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Cape Henlopen Crematory 2/20/98 Frankford, DE 4 ☐ Donation 5 ☐ Othar (Specify) Fuged Service Licega 22. Nama and Addrass of Facility Burbage Funeral Home 108 William St. Berlin, MD nat causad tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, Approximata Intarval Batween Onaat and Death tmmediata Cause (Final CZ/LINOME 40gtall molls diseasa or condition resulting in death) Physician/Medical Examiner Sequentially tist conditions, if any, leading to immadiata cause. Enter Underlying Causa (Diseasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part t. 23b. Dtd tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings available prior to compiation of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yaa 2 ☐ No Be 25. Was case referred to medical 28. Place of Death (Check only ona) axaminar? Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Assidance 6 ☐ Other (Specify) 2 1 Yas 2 No 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Tima of 28c. tnjury at Work? 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Sulcida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homleida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a. Certifiar Medical (Check only one) 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner statad. 29b. Signatura and titia of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year)

or Attending Physician: The lew requires that the death certificate be executed been signed by the should be detached Records. page 2 After this certificate Division of Vital director within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of Hospital To the

Funeral

Director

28a-f show

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Items 23a death

permit. Pages 1 and 2 should be filled within 72 hours effer of Department of Heelth and Mentel Hygiene.

Important: If them 27 is marked other than "natural", or frem any injury or other traumatic event, the marked other pages.

Physician /Medical

Examiner

ettending physician and for use as the burief-transit

P.O. Box 68760.

Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

the Maryland

State Registrar

31. Data filed (Month, Day, Year) FEB 2 0 1998

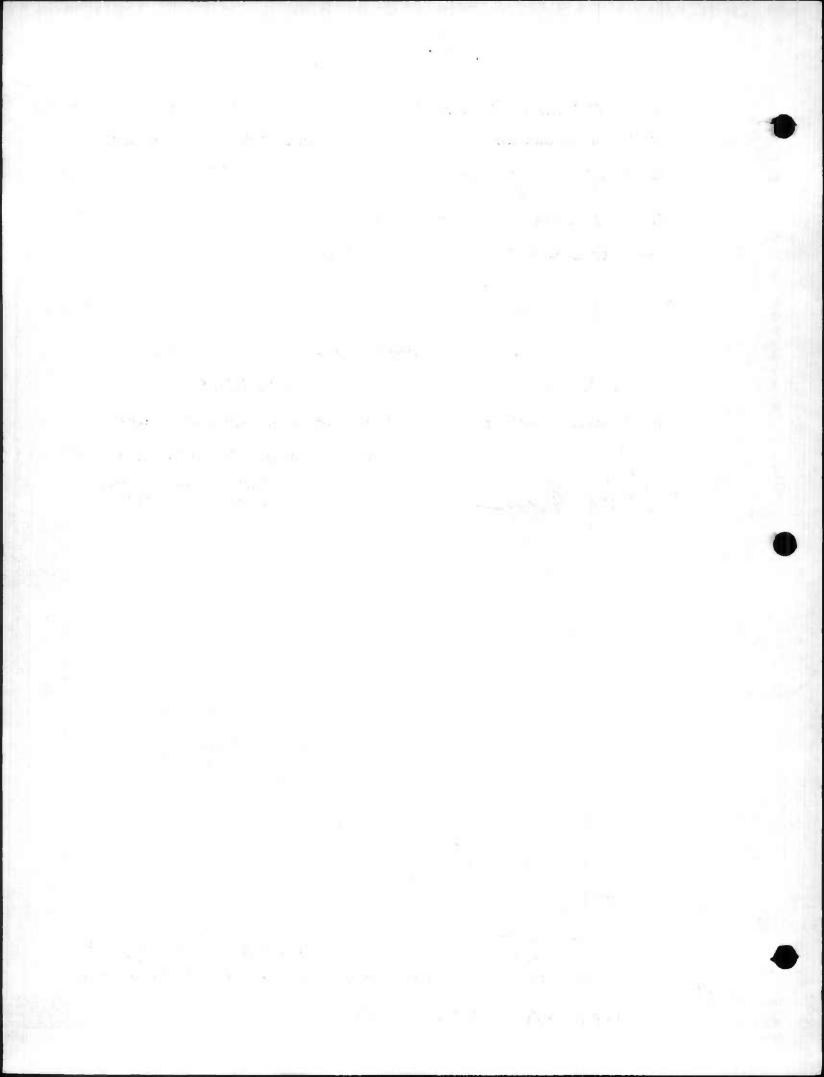
9733 32. Registrar's Signatura

5141-

30. Name and addrass of person who completed causa of death (Itam 23a) (Typa, Print)

Julia Davidson

the Muzy And

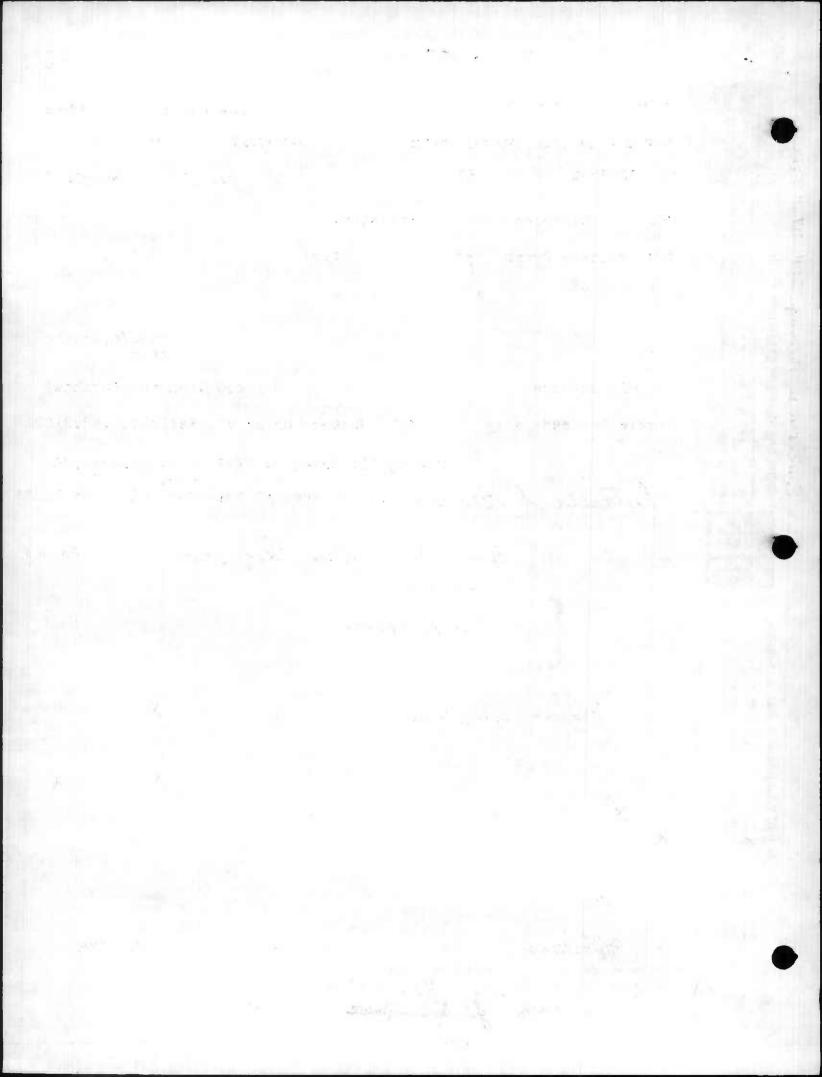


Emerson L. Burbag SS# 219-36-5262

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	PENINSULA REGI	ONAL MEDIC	CAL CENT	CER				ISBU			OMIC	
Funeral	5. Social Security Number	6. Sex 7	7. Age (In yrs. la:	st birthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, De		9. Births	place (State or Fore
Director	219-36-5262	X	58	115.					8/16/	/39	Ma	ryland
and #	10a. Slete 10b. County		10c. City,	Town or Lo	cation						1	Od. Inside City Lim
28a-f show	Md. Wic	omico	10.00	Sal	isbui	cv						1 ☐ Yes 2 🙀 I
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To atte	Lewis Burb									ohnson		
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itam 27 other tr	Gerrie Burba	ge, wite		4596 ace of Dispo			cs Cr	coss	Rd.,	20c. Location	-	Md.2180
	20a. Method of Disposition 1 Buriel 2 Cremetion	3 □Removal from S	0.00	metery, cren	natory or o	ther plac	e)	1	Date	20c. Location	- City or 10	own, State
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Department Important: any Injury once.	21. Signature of Funeral Service I	icensee /	2				s of Facilit			P.O. Bo		
70 E # 0	Talricia	e L. Ll	enne	/)							111,	,Md.218
200	23a. Pert1. Enter the disease, or shock, or heert failure. List	complications that ca only one ceuse on ee	used the death. ech line.	Do not ente	er the mod	e of dyin	g, such es	cardiac	or respiratory e	rresl,		Approximate Intervel Between Onset and Deeth
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within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	(Check only 2 Madical I	xaminer: On the bas and mann	sis of examination er stated.	on and/or inv	estigetion,	, in my o	pinion, dee	th occur	red at the time,	gete end plece,	and due t	o the cause(s)
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	10/ Hude	unt				0	291	05		2/	19/	98
	30. Name end ederess of person	who completed cause	of death (Item 2	23a) (Type,	Print)					-	ξ	
12	Christian Hund	dleston m	.0. 1/	Ole Mi	1ford	54	Sal	Ishur	d, mo			
State	31. Date filed (Month, Day, Year)	32. Re	oistrar's Signatu	ILO .					11			

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene O

To Be Completed by Funeral Director	213–58–7761 Isual Residence of Decedent 0a. State 10b. County	George's 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 13. Was Decedent E Armed Forces? 14. College (1-4or 5+1+1)	(In yrs. lest bit 46 10c. City, Tov ver in U,S.	Yrs. Months Da who or Location 10f. Zip Cod 13. Was Decedent of If Yes, specify C 1□ Yes 25th a. Decedent's Usual Oct Give kind of work do	Lanham e 20706 of Hispanic Origin? (Spe	Februar cation of Deeth 8. Dete of Birth (Month, Dey, Ye 08-21-5)	4c. County of De Prince (9ar) 9. 8 51 Wa Citizen of What (USA	George's Sirthplace (State or Foncountry) 10d. Inside City Lin Serves 2 Country?
miner de D 5. 2 Us	Octors Community Social Security Number 213-58-7761 Isual Residence of Decedent Oa. State Ob. County Prince Ob. Street end Number 1416 4th Stree 1. Marital Status 1. Never Married 3. Widowed 15. Decedent's Elementary/Secondary (0-12) 7. Fathar's Nama (First, Middle, Las James Israel (1)	George's 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 13. Was Decedent E Armed Forces? 14. Was Decedent E Armed Forces? 15. Was Decedent E Armed Forces? 16. Was Decedent E Armed Forces? 16. Was Decedent E Armed Forces? 17. Age	46 10c. City, Tov ver in U,S. o	Yrs. Months Da wn or Location 10f. Zip Cod 13. Was Decedent of If Yes, specify C 1□ Yes 2只t a. Decedent's Usual Oc Give kind of work do	Lanham par if Under 24 Hrs. ys Hours Min. Lanham e 20706 of Hispanic Orlgin? (Spe	8. Dete of Birth (Month, Dey, Ye O8-21-5	4c. County of De Prince (9. B 9. B 51 Wa Citizen of What (USA) 14. Rece - Ar Black, Wi	Seonge's Sinthplece (State or Fon Country) Shington D 10d. Inside City Lin **Exes 2 C Country?
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17 0 18	James Israel (00	wan on t
15	James Israel (7		X-Ray Tec	18. Mother's Name	(First Middle Mai		rnment
15								
20	9a. Informant's Name/Relationship					queline N		•
20	_				eet end Number or Rura			
20	Jacqueline Cope,	Mother	3	614 Jeff Ro	oad, Spring	dale, Mar	yland 2	0774
	Da. Method of Disposition		20b. Plece C	of Disposition (Neme of	niece)	Date 20d	. Location - City of	or Town, State
	Donation 5 ☐ Other (Special Control of the Control			ony Memoria		/21/98 I	andors	Maurelan
			natin			/21/90 1	Jandover	, Maryland
21	1. Signature of Funeral Service Lice	nsee +	•	22. Neme end Ad	Jenkins Fu			
cal Examiner	isease or condition esulting In deeth) requantially list conditions, any, leading to immediete euse. Enter Underlying leuse (Disease or injury tel initiated events	b. Seps	Oue to (or as a	consequence of):				2 day
Cian/M	esulting in death) Lest	d			given in Part I.	23b. Dld tobac	cco use contribu	ite to the cause of de
	Mul tiple	sclerosis				1 ☐ Yes	210 No 3□	Probably 4 ☐ Unk
Completed by	, , , , , , , , , , , , , , , , , , , ,					24e. Was en e performed		Were autopsy findir evelleble prior to completion of ceuse of deeth?
E						1 □ Yes	21110	
	5 Was ones referred to madina						ZULFNO	1 ☐ Yes 2 ☐ No
100	5. Was casa raferred to medical axaminer?	Hospital:		1	28. Place of Death Other:			
2 27	1 ☐ Yes 2 ☑ No	1 Dunpatien		utpatient 3L DOA	4 LI Nursing Hon	ne 5 Residence		pecify)
ertification:	7. Mannar of Death 1. Dratural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not to determined	28e. Plece of Injur	y - At home, fe		Vork? ☐ Yes 2☐ No		t and Number or	Rurel Route Number,
Cert		building, etc.	(Specify)			City or Town, S	1610/	
edica	9a. Certifiar 1 Certifying Pl (Check only one) 1 Medical Example 1	nyalcian: To the best of miner: On the basis of e end menner state	exemination ar	e, death occurred et the nd/or investigation, in m	e tima, data and place, a y opinion, death occurre	nd dua to tha caus d et the tima, dete	a(s) and mannar and piace, end d	as stated. ue to the cause(s)
1000	b. Signeture and title of certifier		-	29c. Lice	ense number	294	Date signed (Mo	nth, Day, Year)
	Parton Fr	relia	1	(-1)	1)42111		2/11	198
/	Nome and different		AL /II	CT P. I. II	043446 While ville		-1.01	70 .
/ 30.	Name end eddress of person who ROINTAN FAR	A 41 CAA	atri (item 23a)	(Type, Print)	4/1/1 :11.	and R	11/2-	6 MAZO

DHMH 16 Rav 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

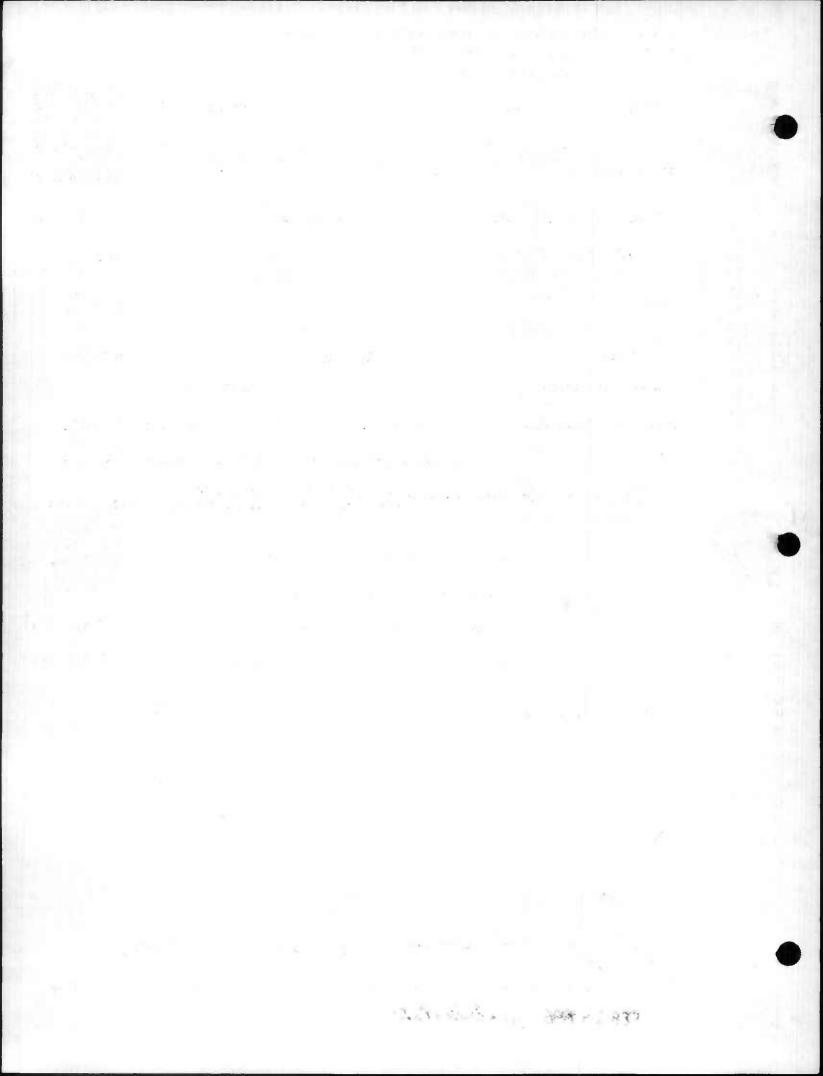
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State of Maryland / Department of Health and Mental Hygiene

						ficate of	Death		g. No.	3 06	99	5
Physic		Decedent's Nema (First, Middla, L. JAMES	CRAIG					2. Deta of Deet Month Februar			3. Time of 0 2:40	
/Medi Exami		4a. Facility Neme (If not institution, gi					4b. City, Town, or I		4c. County			
Funeral Director		579-36-3220		e (In yrs. le		f Under 1 Yaar Ionths Days		8. Date of Birth (Month, Dey, 03–30	Year)	9. Birthplec Country, Washi	e (Stete or	Foreign
and w	1	Usual Residence of Decedent 10a. Stete 10b. County		10c. City.	Town or Locat	ion					Inside City	
Mary!	tor	Maryland Prince	George's			Gle	enarden			100.	1 Yes	
th with the 23e or 28e	al Director	10e. Street end Number 8417 Hamlin	Street #3	01		10f. Zip Code	20706	1	og. Citizen of V	Whet Country USA	?	
A I A I S-UUAU d within 72 hours after death with the Maryland jene. r than "natural", or items 23s or 28s4 show the Wedjes Examper must be notilised	by Funeral	11. Maritei Status 1 □ Nevar Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Yes (Give Yeer or Detes:			S Decedant of I es, specify Cub Yes 2 No	dispenic Origin? (Si an, Maxican, Puert Specify:	pecify Yas or No- o Rican, etc.)		e - American ek, Whita, atc		
within iene.	Completed	15. Decedent's E (Specify only highest gi Elementery/Secondary (0-12) 12th	ducation ade completed) College (1-4or 5	5+)	16a. Deceden (Give kin life. DO	t's Usual Occup d of work done NOT use retire Carpen	duning most of wor d)	king	6b. Kind of Bu	usmass/Indus		18
	Be C	17. Fether's Neme (First, Middle, Las	1)			carpen		ne (First, Middla, M			110110	
should be nd Mental marked o	To	James Edward					Sa	ra Jacks	on			
2 2 2 2		19e. informent's Name/Reletionship					end Number or Ru					
Health Health Hem 27 other tr		James L. Craig, 20e. Method of Disposition	01./5011	20b. Ple	9210 C ace of Disposition metery, cremate	on (Neme of	t Place,		riboro,			
Pages ent of nt: If it		1 Burlel 2 ☐ Cremetion 3 € 4 ☐ Donetion 5 ☐ Other (Special			metery, cremat mony Me				Landove	2.	-	Ъ
pemilt. Pages 1 and Department of Health Important: if item 27 any Injury or other thousants.		21. Signeture of Funeral Service Lice	nsea		22. N J.	ame end Addre B. JENI	ess of Fecility	RAL HOME				
		23e. Pert1. Enter the disease, or conshock, or haart failure. List only	/	the deeth.	Do not anter t	4 Land of dying	over Road	 Landov or respiratory arre 	er, Mar st,	A	proximata	
Physician /Medical Examiner		Immediate Cause (Finel diseasa or condition resulting in death)	· CARS	010		TONA		-RREST		0	terval Betwinset and Dr	eeth
xecuted and il-transit	edicai Examiner	Sequentiatly list conditions, if any, leading to immediate	b. REN	Due to (or	as e consequer	A L C	128) AY	,
rificate be executed g physician and as the bunal-transit	dicai E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest			S e consequen		IMPO	4.515			100	
	100		d. CHR	NIC	6	NAW 7	VUL A	BUSE		4	EAR	-5
death cert a attendin d for use	iciar	Pert il. Other significant conditions	contributing to death by	ut not recult	ting in the unde	duina causa ai	on in Part I	22h Bid to	bacco use co			
requires that the death cer been signed by the attendir should be detached for use	by Physician/N	MACNU			ang in the bloce	nying cause gi	on air oit i.	1 🗆 Ye		3 Probab		Jnknow
D 50 00 CI	Completed b							24a. Was en		24b. Wara avelle comp of dee	bla prior to letion of ca	
The The page	Con							1□ Ye	s at No	1 🗆 Y	es 2 N	No
sicien: The certificate rector, pag	Be	25. Wes case referred to medical exeminar?	Hospitel:			Ott		th (Check only on				
Attending Physician: or death. ector: After this certific by the funeral director,	ion: To	1 Yes 2 No 27. Menner of Deeth 1 Aturel 5 Pending	28e. Dete of Injur (Month, De)	ry 2	28b. Time of Injury	28c. Inju	ry at rk?	ome 5 Reside				
To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be	Certification:	2 Acident investigation 3 Suicide 6 Could not to detarmined	99 Place of Init	ury - At hom c. (Specify)			Yes 2 □ No	28f. Location (St. City or Town	reet and Numb , Stete)	er or Rural R	oute Numb	er,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29e. Certifier (Check only one) Cartifying Pl	nysician: To the best of miner: On the basis of end menner sta	examinetic	edge, deeth oc on end/or Invest	curred et the tid Igetion, In my c	me, dete end plece opinion, death occur	, end due to the ce rred et the time, de	use(s) end <i>me</i> ite end plece, i	enner as stete and due to the	ed. e ceuse(s)	- 3
To th Volthir Comp	Me	29b. Signature and title of certifier	2			29c. Licens	se number	25	d. Dete signe	d (Month, De	y, Year)	
(1//	14	<i>G</i> —			1069		2/1-	1198	?	
(3)		30. Name end eddress of person who					E LNSTE	7135 LA	PGA L	1D 21	77/1	L
Sta		31. Data filed (Month, Day, Year)	32 Registra	ar's Signetu	re a	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	MADIE	-100 N	DEU T	- N - O	114	



	Decedent's Name (First, Middle	Last)		08	illicale	of Death	2. Date of I			3. Time of Deeth
ysician ledical		Ricky E	ugene C	arr					Year 1998	12:11 /
niner	4a Facility Name (If not institution						, or Location of De	ath 4c. Count	y of Deeth	
al	MARYLAND RTE	F 40 ea 6. Sex					PERRYVILLE 1 Year # Under 24 Hrs. 8. Date of Bir			piace (Stata or Fore
	214-72-6895	1 ∑ M 2□F	38	Yrs.	Months C	Days Hours	May 20	Day, Year)), 1959	M	aryland
	Usual Residenca of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation					10d. Insida City Limi
Funeral Director	Maryland	Cecil			Con	owingo				1 ☐ Yes 2 🕅 N
3	10e. Streel and Number	21			10f. Zip Co	ode	10g. Citizen of	What Cou	intry?	
Š	422 Johnson Ros	ad			21918				S.A.	
-	11. Marital Status 11. Never Manied 2 Manies 3 Widowed 4 Divorced	Armed F	2XXIVo ive		Was Deceden If Yes, specify 1 ☐ Yes 2	I of Hispanic Origin Cuban, Mexican, F Mo Specify:	? (Specify Yas or ruerto Rican, etc.)		4. Raca - American Indian, Black, White, etc. Specify: Whit	
-	15. Decedent (Specify only highas	s Education	(Give kind of work			done during most of	16b. Kind of E	Business/Ir	ndustry	
De Collibrated	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT use	retired)			Unkno	
2	Eight Years 17. Father's Neme (First, Middle, L	ast)			Unkno		Nama (First, Midd	dla, Maidan Suma		own
á	Ralpi	n William	Carr,	Jr.		E1	va Kathe	rine Hil	ton	
traumetic event, train To Be Comp	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Malti	ng Address (S	Street and Number of	or Rural Route Nur	lumber, City or Town, State, Zip Code)		
	Ralph W. Carr,		Road, Co	-	-					
eny injury or other tri	20a. Method of Disposition XXBurlel 2 □ Cremetion 4 □ Donalion 5 □ Other (Sp.		State Ple	Place of Disponentery, cree easant G		of Fed Methodi	st 2/20/9	20c. Location 8 Peach Bo		own, State Pennsylvan
	21. Signalure of Funeral Service L 23a. Part 1. Enter the disease, or shock, or heart failure. List of	()	caused the dea each line.	1	Lee A	Address of Facility Patterson 11e, Mary f dying, such as ca	n & Son I yland 21 rdiac or raspiratory	Funeral H 1903-0188 y arrest,	Home	Approximate tnterval Between Onsat and Death
-	tmmediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or a) a consequence of):									
b										
	cause. Enter Underlying Ceuse (Disease or Injury that initiated events	c	Due to /	or as a consec	anonce off:					
· Santa	resulting in death) Last	d	D08 10 (1	01 45 4 (01156)	quence on.					
	Part II. Other eignificant condition	s contributing to d	death but not re	sulting In the L	inderlying cau	se given in Part I.	23b. D	ld tobacco use c	ontribute	to the cause of dea
							1	☐ Yes 2☐ No	3□ Pro	obably 4 Unknown
completed by rugalcial amedic							24a. W	as an autopsy enformed?	a	Vere autopsy finding vailable prior to completion of cause if death?
-							11	BYes 2□No	1	₽Yes 2□ No
1	25. Was case referred to medical examiner?						Death (Check on	ly one)		
0	1 No 2 No			ER/Outpatie			ng Home 5 □ Re			(fy)ROADWAY
ation	27. Menner of Death 1 □ Natural 5 □ Pending 2 ☑ Accident Investig	ation 2/16	of Injury oth, Day Year)	28b. Time of Injury	8.4	. Injury at Work? 1 ☐ Yes 2 ☑ No	nedort	tion Struct		cehich
Certification:	3 ☐ Suicida 6 ☐ Could n 4 ☐ Homicide detami	of be 28e. Plac	a of Injury - AI h ling, etc. (Speci	nome, farm, st	eel, factory, o	offica	281. Location City or Cecil C	n (Street and Num Town, State) pr	ye & Ba	ral Route Number, addy's Seafer
edicai		xaminer: On the b				the time, date and p my opinion, deeth	placa, and due to t	he ceuse(s) end n		
N N	29b. Signature and title of certifier				29c. L	icense number		29d. Date sign	ed (Month	n, Dey, Year)
	1	1 11	ite w		0	C.M.E		FEBRUA	**** 1	17,1998

State Registrar

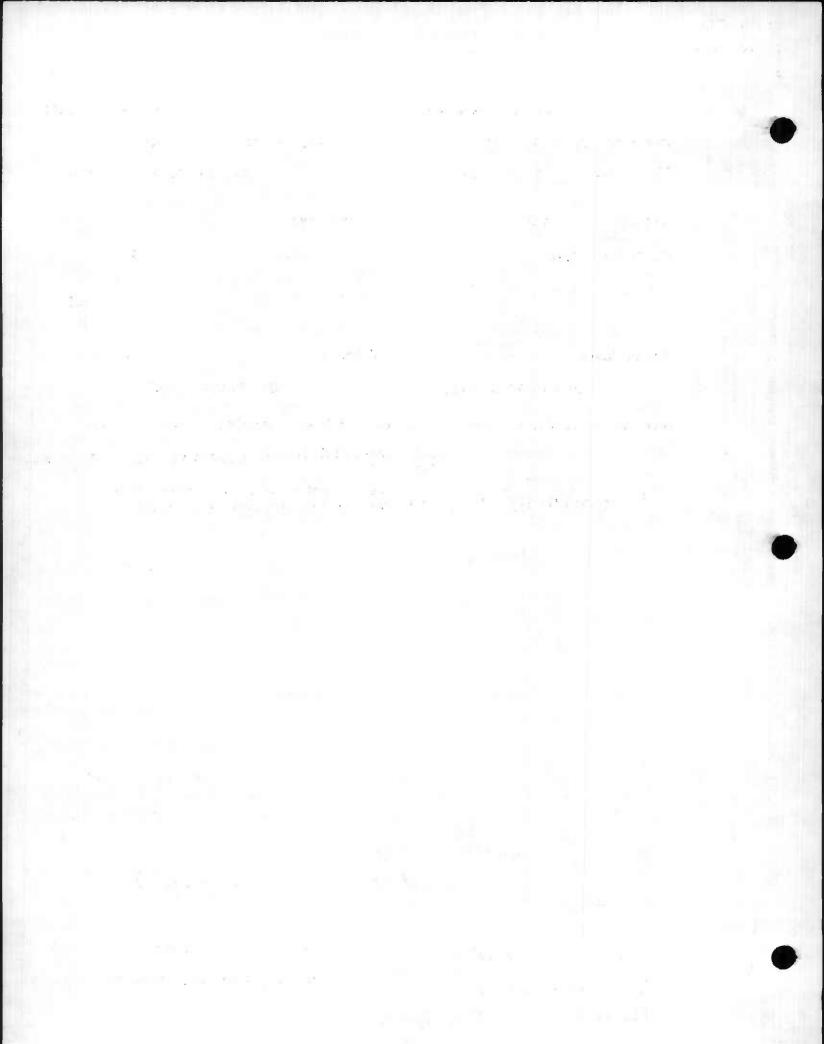
30. Name and address of person and completed cause of death (Item 23e) (Type, Print)

Denns J. Chute no 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 19 1998

Javidson Pendall whit Davidson Randall



214-32-5702

Chamberlin

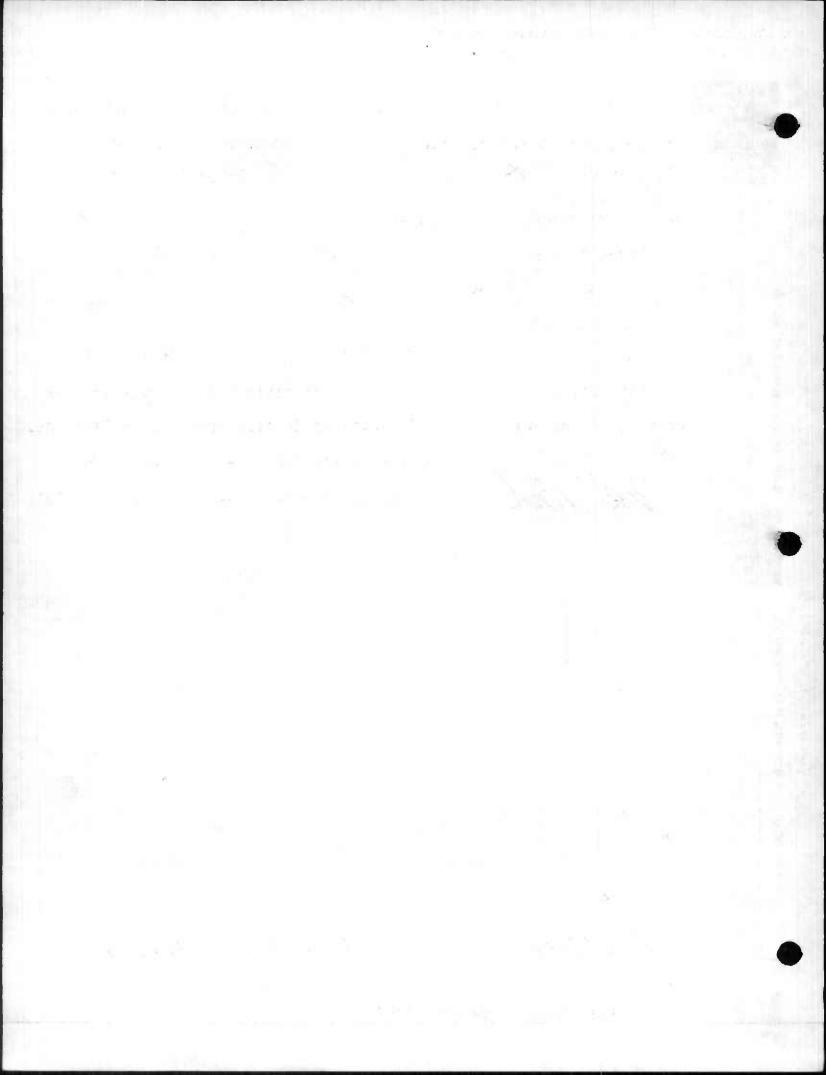
VIRGINIA

		Certificate of	of Death	R	leg. No.	3 0	6997
1. Decedent's Neme (First, Middle, La			101	2. Dete of Dee		Year	3. Time of Deeth
VIRGINI	Α Μ.	CHAMBERLIN		2	7 1	998	0830
4a. Fecility Neme (If not institution, given	re street end number)		4b. City, Town, or	Location of Deeth	4c. County	of Deeth	
PENINSULA REGION			SALIS	BURY	WICC	OMICO	
	I N OFF	o Yrs. If Undar 1 Your Months De			Year)	9. Birthple Countr	ece (Stete or Forei
214-32-5702 Usuel Residence of Decedent	6	8 '''3'		6-15-	29	VA	
10a. State 10b. County	10c. C	ifty, Town or Location				10	d. Inside City Limi
MD. WICOMI	co S	ALISBURY					1 Yes 2□N
10e. Street and Number		10f. Zip Coo	ia	1	Og. Citizen of V	Vhat Countr	v?
108 PRYOR AVEN	UF	21	804		USA		
11. Maritel Status	12. Was Decedent Ever In U	U.S. 13. Was Decedent	of Hispanic Origin? (Specify Yes or No-	14. Raci	a - America	
1 Never Merried 2 Married	Armed Forces? 1 Yas 2 Alo If Yes, Give	1 ☐ Yes 2X	Cuben, Mexican, Puè	по нісел, етс.)		k, White, e	lc.
3 ☐ Widowed 4 ☐ Divorced	Yaar or Dates:	TLI Fes	No Specify:		Specify	WHI	TE
15. Decedent's E. (Specify only highest great programme)	ducation ada completed)	16a. Decedent's Usuel Oc (Give kind of work do	one during most of we	orking	16b. Kind of Bu	sinass/Indu	ustry
Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use re	tired)		D = -		
17. Fether's Neme (First, Middle, Last	4)	WAITRESS	19 Mother's Nice	me (First Middle)	REST		NT
				me (First, Middle, i			
HERMAN WHITMA 9e. Informent's Neme/Reletionship (10h Mailing Address (Ct.		IA WHITE			HITMAN_
		19b. Meiting Address (Str					
LLOYD C. CHAMB	ERLIN 20b.	9701 STEPI	HEN DECA	TUR HGW	Y . UCE.		TY MI
1/2 Buriel 2 ☐ Cremetion 3 ☐	Ramovat from Stete	cemetery, cremetory or other	place)				
1. Signature of Fuseral Service Lice		UNSET MEMOR 22. Nama end Ad		2-11	BERL	IN	MD.
	771.1						
MINUS (1)	ML		FUNERAL		BERLIN		
Enter the diseasa, or com	one ceuse on each tine.	ith. Do not enter the moda of	dying, such es cardia	ic or respiretory err	est,		Approximete Intarvat Between Onset and Deeth
mmediete Ceuse (Finel	ວ ,	7 /					Oriset and Deetin
disease or condition resulting in death)	· Kespirato	Ry tailure				1	
,	Due to (or as a consequence of):				1	
	D						
Sequentially list conditions, fany, teeding to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury	Due to (or es e consequence of):					
Ceuse (Diseese or Injury thet initiated events	C. Division (n					
esulting In death) Last	D) of end	or as a consequance of):					
	d						
ert II. Other significant conditions of	contributing to death but not re-	nulting in the underhiles equal	shan la Red I	20h Did to		delbudo do d	the cause of dea
orth, care agrifficant contantions a	orthodring to dealir out not res	solding in the underlying cause	givan in roll i.				ibly 4 □ Unkn
					45 20110	0020	ibiy 4 dinar
				24a. Wes a	n autopsy	24b. Wer	e eutopsy finding table prior to
				perion	neur	com	pletion of ceusa eath?
				1 🗆 Y	es 200 No	1 🗆	Yes 2□ No
5. Wes case referred to medical			26. Place of De	eth (Check only on			
examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ DOA	Other: 4 Nursing I		enca 6 Dothe	er (Specify)	
7. Menner of Deeth	28e. Dete of Injury (Month, Dey Year)		njury et Work?	28d. Describe ho			
1 Accident 5 ☐ Pending investigation	n		I ☐ Yes 2 ☐ No				
3 Suicida 6 Coutd not b 4 Homicide determined	28a. Plece of Injury - At h building, etc. (Specia	noma, ferm, streat, factory, offi	ca	28f. Location (St City or Town		er or Rurel	Route Number,
- Comordo	building, etc. (Specia	197		Oily or rown	1, 01616/		
9a. Certifier (Check only 2 Medical Exam	nysicien: To the best of my kno	owledge, deeth occurred et the	e time, dete end ptace	e, end due to the co	euse(s) end me	nner es ste	ted.
one)	niner: On the basis of examine end menner steted.	enon entror investigetion, in n	y opinion, deeth occ	uneu et trie time, o	ale enu pieca, é	mia aue to t	ne ceuse(s)
9b. Signeture en little of cartifier			ansa number		9d. Date signed	(Month, D	ay, Yaar)
aul He	8		2487	2	2/7/	198	
). Name end eddress of person who	completed cause of deeth (Iter	m 23e) (Type, Print)	rside Dr				,
Paul Fleur	y M.D.	560 Rive	rside Dr	. Sal	isburn	M.	d.
I. Dete filed (Month, Dey, Year)	32. Registrer's Signa	etura Mandalle	•))	
FEB 0 9	1998 June 1	m (won) - 1					

DHMH 16 Rev 6/95

State

Registrar



Item#3 p	State of Maryland / per Phy G&67 1/8/98 EW	Department of Health and Certificate of Death		giene Reg. No. 98 0	6998
Physician /Medical	Dacedant's Nama (First, Middle, Last) Earl James Chaphe, Sr.	ACCEPTANT OF THE PROPERTY OF T	2. Deta of Daa Month 02	Day Yeer 04 1998	3. Tima of Death 6:30 A.M.
Examiner Funeral Director	4a. Facility Nema (If not institution, giva street and number) Hartley Hall Nursing Home 5. Sociel Security Number 6. Sax 1 MM 2 F 134-28-3627 61	Pocomol birthday) If Undar 1 Yaar If Under 24 I	or Location of Daath ke City	4c. County of Death Worcester , Year) 9. Birthy Coun	placa (Stata or Foreig
death with the Maryland ms 23e or 28e-f show Linual be notified at neral Director	Usual Rasidanca of Dacedent 10a. State 10b. County 10c. City, To	wn or Location NOKe City 10f. Zip Coda			10d. Insida City Llmit 1 ☐ Yes 2 🕱 N
urs after al', or its Evantine by Full		21851 13. Was Decedant of Hispenic Origin If Yas, specify Cuban, Mexican, Pi		USA	can Indian, atc.
Tarylana ZIZIO-0020 2 should be filed within 72 hours after ond Mental Hygiene. Is marked other than "natural, or its reumatic avent, the Medical Examina To Be Completed by Ful	15. Dacedant's Educetion (Specify only highest grada completed) Elamantary/Secondary (0-12) 10 17. Fathar's Name (First, Middia, Last)		Nama (First, Middle,	16b. Kind of Businass/In Constructic Maidan Sumama)	
0.000	Ruth Jean Chaphe / wife 3° 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from Stata	701 Sheephouse Rd., of Disposition (Nama of ary, cramatory or other place) treek Presbyterian Cemete 22. Nama end Addrass of Facility	Pocomoke Data 2/8/98		851 own, Stata
ete be axecuted hysician and the burial-transit the burial-transit and the burial-transit a	Sequentially list conditions, if any, leading to immediate ceuse. Entar Undarlying Causa (Disaase or Injury c.	Holloway-Melson 1 103 Linden Ave., onot antar the mode of dying, such as care Dwy Body De a consequence of): a consequence of):	Pocomoke,	MD 21851	Approximeta Interval Batween Onsat and Death H H H H H H H H H H H H H
The law requires that the de stee has been signed by the cape 2 should be detached completed by Physic	Part II. Other significant conditions contributing to death but not rasulting Progressive Dementia Cenomica, Seigne Hepatites A Screen	in the undarlying ceusa givan in Part I. Hypertenses Reactive	1 U Y	en eutopsy 24b. Word? co	bebiy 4 Unknown of deet bebiy 4 Unknown or ere eutopsy findings allable prior to implation of cause daath?
or Attending siter death. Director: After in by the fune artification	25. Was cesa deferred to medical axaminar? 1	Outpatient 3 DOA Othar: Marsin Tima of Injury M 1 Yas 2 No	28d. Dascribe ho	ance 8 Othar (Specification injury occurred	
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge one on the best of my knowledge one on the best of my knowledge of my knowledge of my knowledge on the best of my knowledge of my knowledge of my knowledge on the best of my knowledge on the best of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my knowledge of my	pa, deeth occurred at tha tima, date and pland/or invastigetion, in my opinion, daath or 29c. Licansa number 29c. Licansa number	courred at tha tima, d	ause(s) and mannar as s late and place, and dua to 19d. Data signed <i>(Month,</i> 2 - 4 - 9	Day, Year)
3+1 State	GREGORIO M. BELLOSO, M. 31. Data filed (Month, Day, Year) FFR 1 0 1000	.D.; 5302 CHINAS	BERRY D	RIVE, SALIS	2180 BURY, M

State Registrar Dennis

31. Dete filed (Month, Day, Year)

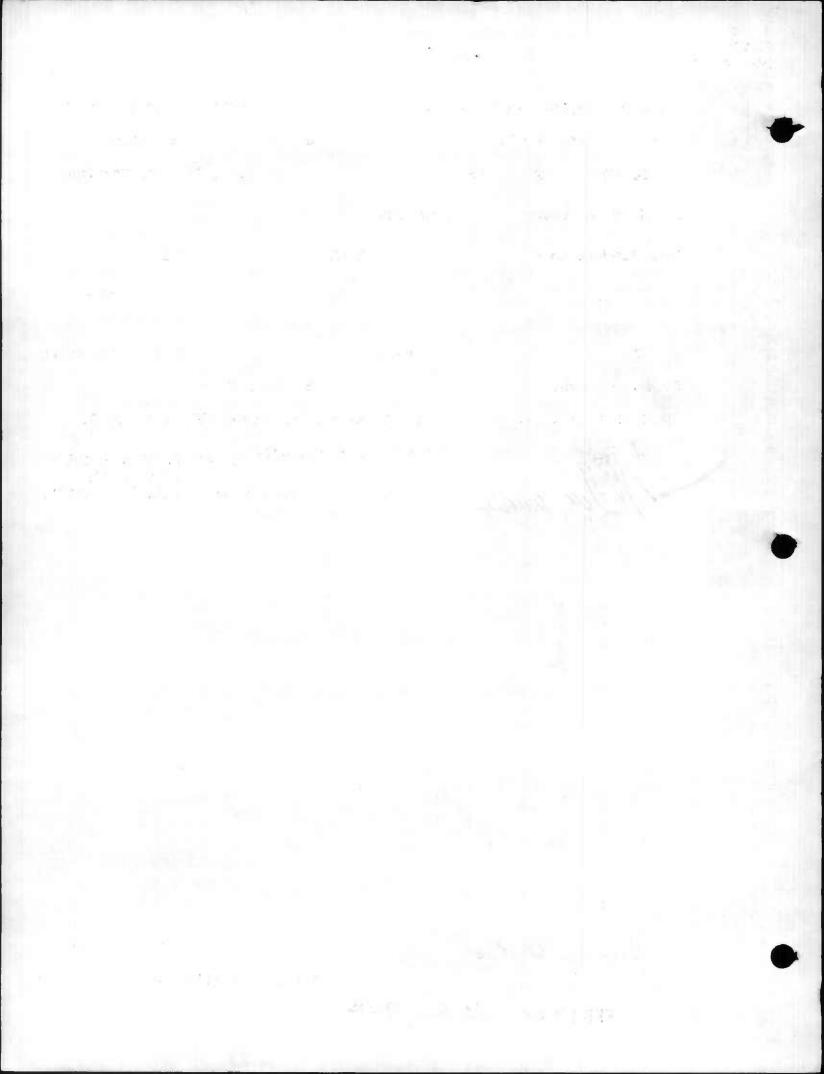
FEB 1 9 1998

32. Registrer's Signature

Guha Davidson-M

111 Penn Street, Baltimore, Maryland 21201

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** MAE CAMPBELL ROSA .45Pm /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerset Edw.W.McCready Memorial Hospital Crisfield If Undar 1 Yaar If Undar 24 Hrs.
Months Days Hours Min. 8. Data of Birth (Month, Day, 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Country) **Funeral** 1□M 2 F 59-36-3735 85 Yrs Director 10-Usual Rasidance of Decedant permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hyglena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumstic event, to a Medical Exprinter mast be notified. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Funeral Director ocomoKe Norces 10e. Street and Number 10g. Citizan of What Country? 1813 2185 Was Decedant Evar in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whifa, atc. 11. Marital Status 12. 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 □ Divorced Completed 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) OOK 3rd grado 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be 2 narles 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) POCOMOKE OMOKE Md. 21851 20c. Location - City or Town, Stata Diane Tall 20a. Mathod of Disposition -daughter 20b. Plece of Disposition (Nama of cematary, crematory or other place) Data 1 Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) New macedonia menorial 2 2-11-98 Pocomo Ke, md, 2185, 21. Signature of Funaral Sarvice License 22. Nama and Addrass of Facility Bennie Smith Funeral Home City, md, 21851 Pocomoke BOX 331 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or haert failure. List only one cause on each line. Approximata Intarval Batwean Onsat and Death **Physician** Immediete Ceuse (Finel disaasa or condition rasulting In daath) /Medical 2 WKs. ACUTE RENAL FAILURE Examiner Dua to (or as a consequence of): Physician/Medical Examiner SEPSIS attanding physician end for use as the burial-transit The law requires that the death certificata be executed Sequantially list conditions, if any, leeding to immadiata cause. Entar Undartying Causa (Disease or Injury that Initiated avants rasulting in death) Last Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760 Dua to (or as a consaquanca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ BLEEDING. 24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy Completed has 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 ☐ No Mospital or Attending Physician:
 24 hours effer death.
 Funeral Director: Affar this certifica 25. Was casa rafarred to medical axaminar?
1 ☐ Yes 2 No Be 26. Placa of Daath (Check only ona) Hospital: Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Lo 2 ER/Outpatient 3□ DOA 27. Mannar of Deeth 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural
2 Accidant 5 Panding Investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, straet, factory, offica building, atc. (Specify) 4 Homlcida 1 Certifying Physician: To tha best of my knowladge, deeth occurred at tha tima, date and place, and dua to the causa(s) and mannar as stated.

2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, deta and place, end dua to the cause(s) and mannar stated. 29a. Cartifiar Medicai (Check only one) within 2 To the To the 29b. Signatura and titla 29c. Licansa number 29d. Data signed (Month, Day, Year) PHY SICIAN. 30. Neme end eddrass of person who completed cause of deeth (Item 23e) (Type, Print) Thirumaleshwara Kanchana, Main St., Crisfield, Md. 21817 32. Ragistrar's Signature State I felia Davidson Randall

DHMH 16 Rev 6/95

Registrar

